Royal Brompton & Harefield Hospitals Specialist Care - Wimpole Street

Quality Report

Royal Brompton & Harefield Hospitals Specialist Care - Wimpole Street
77-78 Wimpole Street
London
W1G 9RX
Tel: 0207 3497713
Website: www.rbhh-specialistcare.co.uk/wimpole

Date of inspection visit: 21 to 22 January 2020
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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?	Not sufficient evidence to rate
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

Royal Brompton & Harefield Hospitals Specialist Care-Wimpole Street is operated by Royal Brompton and Harefield NHS Foundation Trust. The service has no

Summary of findings

overnight beds. Facilities include outpatient and diagnostic facilities. The provider, Royal Brompton and Harefield NHS Foundation Trust, is a specialist heart and lung trust.

The service provides outpatients consultations with the trust's cardiologists and respiratory specialists, and diagnostic imaging. Diagnostic imaging facilities include magnetic resonance imaging (MRI), computerised tomography (CT) scanning, X-ray and positron emission tomography–computed tomography (PET-CT) scanning. A CT scan uses a number of x-rays from around the body to create a three-dimensional picture of tissue and organs. The service is one of a limited number of UK centres offering cardiac PET imaging with rubidium. This type of scan uses a mild, radioactive dye called rubidium to highlight the areas of the body where cells are more active than normal to detect disease. Together, a PET-CT scan can detect whether there's a blood supply shortage or blockage. We inspected both the outpatients and diagnostic imaging core services.

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 21 and 22 January 2020. The inspection was unannounced (the provider did not know we were coming).

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.

The main service provided by this hospital was diagnostic imaging. Where our findings on diagnostic imaging – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the diagnostic imaging service level.

Services we rate

This was the first time we had inspected this location since it registered with CQC in 2016. We rated it as **Good** overall.

We found good practice in relation to outpatients and diagnostic imaging:

- 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. They received training on how to recognise and report abuse.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment competently. Staff managed clinical waste well.
- Staff completed and updated risk assessments for patients and removed or minimised risks.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.
- The service managed patient safety incidents well. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients to minimise their distress. They supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

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- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. People could access the service when they needed it and received the right care promptly.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

We found outstanding practice in relation to diagnostic imaging:

- The service used novel PET-CT imaging techniques to attain detailed images of the heart and respiratory system. The radioactive substances required for the scan were generated on-site and required significant expertise to set-up and run. The specialist cardiac PET-CT imaging conducted at the site was mainly used by NHS patients from the trust which was a tertiary centre with a national patient cohort. The modality was cost intensive and therefore not readily available throughout the UK.

However:

- The provider's practising privileges policy (relevant to three consultants who held practising privileges at this location) did not include information on how practising privileges were reviewed, focusing instead on the granting of these privileges.
- Response rates to patient surveys were low.

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. Details are at the end of the report.

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and the South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Outpatients	Good	Outpatients consultations represented a smaller proportion of activity at this location. The main service was diagnostic imaging. Where arrangements were the same, we have reported findings in the diagnostic imaging section. We rated this service as good because it was safe, caring, responsive and well-led. We inspected, but did not have enough evidence to rate, the effective domain.
Diagnostic imaging	Good	Diagnostic imaging was the main activity at this location. Where our findings on diagnostic imaging also apply to the outpatients' core service, we do not repeat the information but cross-refer to the diagnostic imaging section. We rated this service as good because it was safe, caring, responsive and well-led. We inspected, but did not have enough evidence to rate, the effective domain.

Summary of findings

Contents

Good

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Services we looked at
Outpatients; Diagnostic imaging

Summary of this inspection

Background to Royal Brompton & Harefield Hospitals Specialist Care - Wimpole Street

Royal Brompton & Harefield Hospitals Specialist Care-Wimpole Street is operated by Royal Brompton and Harefield NHS Foundation Trust. This location opened in 2016. It is an NHS service in London, although this location mainly treats the trust's private patients. As a specialist heart and lung trust, Royal Brompton & Harefield NHS Foundation Trust takes referrals from all over the country and does not have a local population in the traditional sense, as such. The service also treats private patients from overseas; with the largest group of overseas patients travelling from the Middle East. The service mainly treats adults, but also treats a small number of children, from birth to 18 years, (approximately 10 children each month) in a dedicated paediatric outpatient clinic. The same number of children also undergo simple diagnostic tests at this location.

This was our first inspection of this location since it registered with CQC in 2016. We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 21 and 22 January 2020. The inspection was unannounced (the provider did not know we were coming).

Our inspection team

The team that inspected this location was led by Kate Stoneman, CQC inspection manager (interim) and comprised two CQC inspectors, a CQC assistant inspector and two specialist advisors with expertise in diagnostic imaging and outpatients.The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

Information about Royal Brompton & Harefield Hospitals Specialist Care - Wimpole Street

Royal Brompton & Harefield Hospitals Specialist Care-Wimpole Street has no overnight beds and is registered with CQC for the following regulated activities:

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

During the inspection, we visited all clinical areas of the service. We spoke with 20 members of staff including registered nurses, allied health professionals, administrative staff, medical staff and senior managers. We spoke with 11 patients. During our inspection, we reviewed 16 sets of patient records and a range of policies and performance data.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with CQC, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (October 2018 to September 2019)

- In the reporting period October 2018 to September 2019, there were 4,032 new and 7,126 follow up outpatient appointments, of which 100% were privately funded.
- In the same period, there were 14,161 diagnostic screening appointments. Of these, 2,460 (17%) were NHS-funded, and 11,701 (83%) were privately funded.

Track record on safety

- In the reporting period October 2018 to September 2019, the service reported no never events and no

Summary of this inspection

serious injuries. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

- The trust received no formal complaints relating to this location in the reporting period October 2018 to September 2019.

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 controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment competently. Staff managed clinical waste well.
- Staff completed and updated risk assessments for patients and removed or minimised risks.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave agency and locum staff a full induction
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.
- The service managed patient safety incidents well. When things went wrong, staff apologised and gave patients honest information and suitable support.

Are services effective?

Not sufficient evidence to rate

We inspected, but did not have sufficient evidence to rate, the effective key question at this location.

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. There was an induction and probation period for clinical staff during which clinical competencies were assessed.
- Healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Summary of this inspection

Are services caring?

Good

We rated caring as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Are services responsive?

Good

We rated responsive as **Good** because:

- The service planned and provided care in a way that met the needs of patients.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- People could access the service when they needed it and received the right care promptly.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Are services well-led?

Good

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

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

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

We found outstanding practice in relation to diagnostic imaging:

- The service used novel PET-CT imaging techniques to attain detailed images of the heart and respiratory system. The radioactive substances required for the scan were generated on-site and required significant expertise to set-up and run. The specialist cardiac PET-CT imaging conducted at the site was mainly used by NHS patients from the trust which was a tertiary centre with a national patient cohort. The modality was cost intensive and therefore not readily available throughout the UK.

However:

- The provider's practising privileges policy (relevant to three consultants who held practising privileges at this location) did not include information on how practising privileges were reviewed, focusing instead on the granting of these privileges.
- Response rates to patient surveys were low.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Good	Not rated	Good	Good	Good	Good
Diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Not rated	Good	Good	Good	Good

Good

Outpatients

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients services safe?

Good

This was our first time inspecting this service. We rated safe as **good.**

Mandatory Training

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

Nursing staff received and kept up to date with their mandatory training. All staff were required to complete relevant mandatory training modules as part of their induction and to complete refresher training as required. Training was delivered through a mix of e-learning programmes and face-to-face practical training days. The mandatory training was comprehensive and met the needs of patients and staff.

The clinical nurse manager monitored mandatory training and alerted staff when they needed to update their training. Staff completed online training modules on the trust's e-learning system. Staff told us they were given time to complete this training within working hours.

The trust set a target of 85% for completion of mandatory training. In the outpatient department, the 85% target was met for five of the six mandatory training modules for which qualified nursing staff at Wimpole Street were eligible, with 100% completion for information governance, moving and handling patients, fire safety, health and safety, and infection control level two. Only five out of six staff had completed adult basic life support training as of September 2019. We saw evidence on inspection that staff had been booked on to any courses they were required to complete.

The trust reported no medical staff working within outpatients at Wimpole Street. All medical staff who carried out consultations at the site worked for the trust at other sites (and completed their mandatory training there) or completed their mandatory training at other substantive places of employment. The trust monitored their compliance with mandatory training annually.

The trust reported no allied health professional staff working within outpatients at Wimpole Street.

(Source: Routine Provider Information Request (RPIR) – Training tab)

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.

The trust set a target of 85% for completion of safeguarding training. All staff had completed 'prevent basic awareness' training. Prevent works to stop vulnerable individuals from getting involved in or supporting terrorism or extremist activity.

As of September 2019, 100% of staff had completed safeguarding children level one training. One member of staff had not completed safeguarding adults level two training, and two members of staff had not completed safeguarding children level two training. At the time of inspection, all nursing staff were compliant with

safeguarding adults and children training level two, with any staff who did not have level three training booked on to complete this. All staff were required to complete level three training.

Nursing staff received training specific for their role on how to recognise and report abuse. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. All members of staff we spoke with understood their responsibilities for safeguarding patients and reporting any potential safeguarding concerns. There were clear processes, and staff were able to describe the necessary steps they would take to address concerns; they could describe how to access the policy on the trust intranet and who to speak to for advice. The hospital's safeguarding policies were within their review date and included information on female genital mutilation (FGM).

The clinical nurse manager was the safeguarding lead for the site and described how he attended the quarterly safeguarding committee and linked in with the wider trust safeguarding teams. The trust had dedicated safeguarding adult and safeguarding children teams who had representatives who sat on local safeguarding board.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Cleanliness, infection control and hygiene

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

The service had effective infection prevention and control (IPC) procedures. The IPC team was based at another trust location but provided cover for the Wimpole Street site. There was a quarterly IPC committee.

All areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up to date and demonstrated all areas were cleaned regularly. Cleaning staff followed appropriate IPC procedures, including using specially designated colour coded equipment to clean different areas. Staff followed a daily cleaning rota and maintained a record of which areas had been cleaned. The small range of children's toys were cleaned in between each use.

The department participated in both local and trust-wide audits to assess compliance with IPC requirements and provide assurances around cleanliness. In the last annual trust-wide IPC audit in 2019, the site scored 95% compliance overall. We saw issues identified through these audits were rectified by taking appropriate action.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE (gloves and aprons) were available throughout the department and we observed staff using them in line with best practice to keep patients safe. Staff had access to appropriate handwashing facilities. Staff had access to sinks in clinical areas including consultation and treatment rooms. Monthly hand hygiene audits were completed for both nursing and medical staff, with compliance rates for the three months prior to inspection standing at 100% compliance.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. There were processes in place to decontaminate reusable equipment.

In the case of suspected communicable disease, the patient would be attended to immediately and placed under transmission-based precautions to minimise the exposure time of other people in the waiting room.

Environment and equipment

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

The design of the environment followed health building notes (HBNs). The service had suitable facilities to meet the needs of patients and their families. Some children were seen in the department, with consultations taking place in one specific consultation room. The waiting area outside would only be used for paediatric patients at these times, with no facilities for making hot drinks provided there, to ensure the safety of children.

The service had enough suitable equipment to help them to safely care for patients. We saw portable equipment displayed a sticker with its most recent testing date. All the items checked were within date for testing.

Emergency equipment was readily available, with two separate adult and paediatric trolleys on the first floor

and grab bags on the second and fourth floors. There were also evacuation chairs for patients who may have collapsed in the event of a fire. Staff checked both adult and paediatric resuscitation equipment against a checklist to ensure essential equipment was available and in working order. We saw there was one missed weekly check on the grab bag on the fourth floor. This was rectified immediately when we brought it to the attention of staff.

Staff disposed of clinical waste safely. We saw clinical and domestic waste bins were available and clearly marked for appropriate disposal. Staff followed waste segregation procedures such as 'management and disposal of healthcare waste' (Health Technical Memoranda 07-01). Sharps bins were correctly assembled, labelled and disposed of in line with safer sharps regulations.

Disposable equipment and clinic room supplies, such as dressings and syringes, were stored in an ordered and tidy manner. All items we checked were within their expiry date.

Assessing and responding to patient risk

Staff identified and quickly acted upon patients who were at risk of deterioration or became unwell within the department.

Staff attended daily safety briefings each morning to share key information to keep patients safe. Staff were made aware when patients with additional support needs, or children, were due to attend the department. There was a paediatric consultant on site when children were seen in the department.

Senior staff informed us patients who were acutely unwell were not seen in the department. Any children seen were not subjected to any tests and were seen for consultation only, so were at low risk of deterioration. Following inspection, we were provided with documented and appropriate exclusion criteria for patients seen on site, and what would require patients to be referred or diverted to the main trust hospitals.

Staff had clear guidance and training on what to do if a patient became unwell within the department. There were emergency call bells throughout the building, which were connected to bleeps the resuscitation team held. Roles for the resuscitation team were assigned each morning in the daily safety briefing. All bleeps were checked daily to ensure they were operational. Mock crash calls took place every quarter, with debriefs identifying any improvements to the process.

There was always one member of staff with advanced life support (ALS) training who would lead in the event of a patient collapse. This was usually a clinical fellow, but two other members of staff had been trained in case they were unavailable.

At the time of inspection, the clinical nurse manager and three registered nurses held a current paediatric intensive life support (PILS) qualification. We saw evidence the three registered nurses who did not currently hold a PILS qualification had been booked to complete this course.

Nurse staffing

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

During inspection, the service had enough nursing and support staff to keep patients safe. The department worked with staff on either long day shifts (8am to 9pm), early shifts (7.45am to 3.45pm) or late shifts (1pm to 9pm). These would vary with the consultations booked in on each day. On the days we were present, there were two registered nurses and one healthcare assistant working at most times.

The clinical nurse manager accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift. Although there are no national standards or guidelines on how outpatient clinics should be staffed, the service ensured there was always at least one registered nurse on duty to support the healthcare assistants.

The service had low sickness rates. Staff told us that where gaps in the rota were identified, due to sickness or short notice absence, for example, cover was arranged using existing staff working an extra shift as bank staff. The clinical nurse manager could not recall a time when

agency staff had to be used but this remained an option if needed. Managers were able to describe the processes to ensure agency staff had a full induction and understood the service.

There were arrangements for supporting new staff at the hospital, including an induction and supernumerary period during which clinical competencies were assessed. Staff we spoke with were satisfied with the induction process and how it prepared them for their role.

Between October 2018 and September 2019, the average annual establishment of qualified nurses was seven wholetime equivalents (WTE). The annual vacancy rate was 10%, against a trust target of 10%. The annual turnover rate was 16%, against a trust target of 14%. The annual sickness rate was 3.2%, against a trust target of 3%. No agency staff were used.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Nurse staffing rates within outpatients at Wimpole Street were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for sickness. There was not enough variation in vacancy or turnover rates over the last 12 months for registered nurses to comment on the performance of these metrics over time.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

The service had access to registered children's nurses in other areas of the trust that could provide advice at all times.

Medical staffing

The trust reported no medical staff working within outpatients at Wimpole Street. Doctors who held consultations in the outpatient service were associated with the main hospital sites rather than this outpatient department, so this data was not collected or monitored by the outpatient department directly.

Records

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

Staff kept records of patients' care and treatment. Patient notes were comprehensive, and all staff could access them easily from any computer on site using a secure login. The service had access to centralised electronic records management systems. Consultants usually used one or both systems to record consultation notes and store copies of clinic or referral letters. These could be dictated directly or sent to medical secretaries to type up and send on to the patient and any appropriate professionals, such as GPs.

Records were stored securely. Any paper notes were collected by courier in secured tagged bags and sent to the main trust medical records department for scanning onto the electronic system and shredding.

We reviewed six sets of patient records and found notes were generally completed to a high standard and detailed the plan for the patient going forward.

When appropriate, staff told us records would include details of patients' mental health, learning disability and dementia needs alongside their physical health needs. There was an electronic flagging system whereby some of these additional needs could be flagged and identified by staff throughout the trust.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff stored and managed medicines and prescribing documents in line with the provider's policy. A small range of medicines were stored in locked cupboards. There were no controlled drugs held on site.

The service stored refrigerated medicines within the manufacturer's recommended temperature range to maintain their function and safety. Staff monitored medication fridge temperatures. We saw staff had taken appropriate action when temperatures were recorded outside of the required range.

Good

Outpatients

Doctors used personalised headed paper to write prescriptions which were printed off as required. Any blank headed paper was kept securely in a locked cabinet. Staff followed the hospital's policy for issuing prescriptions to patients. The trust carried out annual medicine audits, with the last completed in November 2019. We saw items identified from this audit, such as more consistent recording of fridge temperatures, had taken place.

Staff followed current national practice to check patients had the correct medicines and provided specific advice to patients and carers about their medicines. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Incidents were raised though the trust's electronic reporting system.

From February 2019 to January 2020, the outpatient department reported six incidents related to patients being seen in the outpatient service. All incidents resulted in 'very low' or 'low harm'. Communication and issues with facilities were the most common type of incident reported.

There were processes for investigating incidents and staff informed us feedback was shared at a local level by managers in monthly meetings and through trust-wide communication when appropriate. Staff met to discuss the feedback and look at improvements to patient care. There was evidence changes had been made as a result of feedback. Staff gave examples of changes in practice from incidents, such as learning not to be solely reliant on IT based systems, and a new process for sending blood samples.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From December 2018 to November 2019, the trust reported no never events for outpatients at Wimpole Street.

(Source: Strategic Executive Information System (STEIS))

Staff knew how they would report serious incidents clearly and in line with trust policy. In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in outpatients at Wimpole Street which met the reporting criteria set by NHS England from December 2018 to November 2019. Managers told us they would debrief and support staff after any serious incident.

(Source: Strategic Executive Information System (STEIS))

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. There had been no incidents meeting this threshold within the last 12 months.

Are outpatients services effective?

Not sufficient evidence to rate

This was our first time inspecting this service. We do not rate effective for this core service.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

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

based on National Institute for Health and Care Excellence (NICE) guidance. Staff were able to access trust policies and procedures on the trust intranet. Some local standard operating procedures existed for areas such as phlebotomy or chaperoning, which were tailored to the site specifically.

Only consultations took place in the outpatient department. The service did not participate in national benchmarking or national clinical audits, as these are not widely available for this core service.

Policies we reviewed were within their review date. Staff had access to guidance documents for local processes and procedures where relevant, for example, on the escalation of a deteriorating patient or business contingency arrangements.

At the daily safety briefing, staff informed us they discussed any specific psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

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

Patients had access to water in waiting areas. Sandwiches and snacks were provided to patients staying longer on site.

Consultants were able to refer patients onwards to dietitians and speech and language therapists if patients required further assessment or support with eating or drinking.

Pain relief

Due to the nature of the service, staff were not required to assess and monitor patients regularly to see if they were in pain.

Most patients attended for consultations on an outpatient basis only and therefore their pain levels were not routinely assessed. Staff were able access appropriate pain relief in the form of paracetamol for patients within the outpatient department if required. Any reported pain would be assessed using the numeric rating scale (NRS) and verbal rating scale (VRS). The service did not provide a pain management clinic but could refer on to other services as required.

Patient outcomes

Staff conducted some local audits to monitor the effectiveness of care and treatment.

The outpatient service did not generally participate in national clinical audits as there were no relevant national audits for this core service. Staff carried out monthly audits to assess hand hygiene compliance and environmental infection control. Audit results for the six months before our inspection showed high levels of compliance with the trust targets. Managers shared and made sure staff understood information from the audits.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. There were arrangements for supporting new staff at the hospital, including an induction and supernumerary period during which clinical competencies were assessed. Staff we spoke with were satisfied with the induction process and how it prepared them for their role.

Managers supported staff to develop through yearly, constructive appraisals of their work. We saw all nurses and healthcare assistants had recent appraisal or probation discussion records. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

From October 2018 to September 2019, 95.8% of staff within the outpatient department at Wimpole Street received an appraisal compared to a trust target of 80%.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

The service worked with consultants employed substantively elsewhere in the trust, or a small number of consultants employed through practising privileges arrangements. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. The trust informed us the practising privileges applications of these consultants had been reviewed by

members of the practising privileges committee remotely, not in a formal committee meeting. The decision to award practising privileges sat with the medical director and the managing director of private patients. Although the trust informed us consultants with practising privileges at the service had their General Medical Council (GMC) registration and appraisals checked on an annual basis as part of the clinical governance process, it was not clear what governance processes facilitated this. The practising privileges policy did not include information on how practising privileges were reviewed, focusing on the granting of these privileges. We were informed the practising privileges committee reviewed new applications remotely.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend.

Multidisciplinary working

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

We saw care was delivered in a coordinated way. Staff in different teams were involved in providing person-centred care. There was evidence of staff working together to meet patients' needs. Staff could call for support from other disciplines such as diagnostic testing. Patients could see all the health professionals involved in their care in one-stop clinics. This benefitted patients as they avoided attending multiple appointments on different days. No specialist nurses were present in clinics at the time of our inspection.

Seven-day services

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

The service was open for outpatient appointments from 8am to 9pm, Monday to Friday, and

9am to 5pm on Saturdays.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support in the waiting areas. There were leaflets and contact details of relevant organisations that offered support and advice to patients.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Most consent for outpatient consultation appointments was implied. This meant it did not necessarily need to be documented in the patients notes. For example, when taking a patient's blood pressure, the nurse would ask the patient to hold out their arm, so they could attach the strap. If the patient complied with this request, then consent was implied. No invasive procedures requiring written consent were performed in the department.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, doctors made decisions in their best interest, taking into account patients' wishes. In the last 12 months prior to our inspection, no capacity assessments or best interest decisions were required on the site. We were provided with evidence of how this process would be instated and recorded.

The trust set a target of 85% for completion of MCA and DoLS training. All staff had completed this training within the department.

The trust reported no medical staff or qualified allied health professionals working within outpatients at Wimpole Street.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Good

Outpatients

Are outpatients services caring?

Good

This was our first time inspecting this service. We rated caring as **good.**

Compassionate care

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

Staff were discreet and responsive when caring for patients. Nurses and doctors introduced themselves to patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients were able to bring a relative, carer or friend into their appointments with them if they needed support.

Patients said staff treated them well and with kindness. We spoke with four patients, and all spoke positively about how they had been treated by staff. One patient described staff who were “amazing” and “very nice” and were always happy to answer any questions.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff followed policy to keep patient care and treatment confidential. Between October and December 2019, 189 patients confirmed they felt their privacy and dignity was respected in the patient survey. Consultations took place in private rooms and patients were able to speak to the receptionist without being overheard.

Nursing staff acted as chaperones to support patients during intimate examinations, although they did not receive formal training for this. There was a standard operating procedure that acted as a guideline for staff, with an authorisation for chaperoning form available in English or Arabic attached. Patients were able to request a chaperone of the same gender.

Patients gave positive feedback about the service. Of those patients who provided feedback to the service in 2019, overall positive scores for the service ranged between 91% and 99%. The Friends and Family Test (FFT) was used to gather feedback from patients so they could give comments on their experiences and state whether they would recommend the service. Between October and December 2019, FFT scores ranged between 98% and 100%. Patient feedback was collected and shared with all staff during the monthly staff meeting.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. The service had dedicated patient journey coordinators, who could provide support to patients who were anxious or nervous about their appointments.

Staff described how they would support patients who became distressed in an open environment and would help them maintain their privacy and dignity. Staff were able to tell us how they would support patients at distressing times. Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. We saw patient needs were discussed during daily safety briefings.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families and carers in a way they could understand. Staff supported patients to make informed decisions about their care. Following their appointment, patients understood how and when they would receive any test results and details of future appointments.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Between October and December 2019, between 98% and 100% of 189 patients surveyed across all months confirmed they had no concerns or fears about their experience at the service.

Good

Outpatients

The service provided information and support with the payment of fees. There was written information available on how to pay for treatment, and guide prices for self-pay patients available online.

Are outpatients services responsive?

Good

This was our first time inspecting this service. We rated responsive as **good.**

Service delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of patients. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the patient population. The general manager told us how they were exploring other specialties that would complement the heart and lung focus of the trust. Currently, offering a prostate PET service was being explored.

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

Facilities and premises were appropriate for the services being delivered. There was clear signage throughout the building in both English and Arabic. There was sufficient seating for patients, and those accompanying them, within waiting areas. People had access to water, magazines, information leaflets and toilets. Although there was no separate waiting area for children, they usually attended at the same time in a dedicated paediatric clinic, so a waiting area outside of the consultation room was used so children and families waited separately to adults using the service. A small range of toys and books were available for younger children. There was access to Wi-Fi throughout the building.

Telephone and internet calls were available as an alternative to face-to-face appointments where required.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

The service was accessible to wheelchair users, with a step that raised automatically at the entrance, wide corridors and lifts throughout. Transport could be arranged for patients with mobility issues.

The service had systems to help care for patients in need of additional support or specialist intervention. Although few patients with complex needs attended the service, staff were able to describe how they would make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. 'This is me' documents and patient passports were available to staff, and a flag could be added to a patient record to indicate any enhanced needs. Staff told us extended or double appointments could be offered if necessary, with time of day suited to the patient. Any enhanced needs would be flagged at the time of booking to ensure suitable arrangements were in place. Staff had access to trust wide support and advice on caring for patients with enhanced needs if required.

Staff told us they could access help from interpreters or signers when needed. On site liaison officers who spoke Arabic were available, and interpreters who spoke other languages could be requested. The service could obtain information leaflets available in languages spoken by the patients. Some leaflets were available in Arabic and others could be requested.

Access and flow

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

Outpatient clinics were held at various times from 8.30am to 9pm, six days a week. Managers monitored and took action to minimise missed appointments. Staff ensured patients who did not attend appointments were contacted. The service did not routinely collect do not attend (DNA) rates as the outpatient service saw self-pay patients who tended not to miss their appointments.

Good

Outpatients

Patients could contact the service by email or telephone to enquire about consultations. There were no waiting times for patients booking themselves in at the service. Same day or next day appointments were available if needed.

The time waiting once on site was not formally audited, although this was electronically recorded and could be accessed in case of any issue or complaint. On rare occasions when appointments ran late, staff told us they kept patients up to date. In the 12 months before our inspection, the service reported no cancelled consultations.

Any blood samples were collected every two hours as required during clinic opening hours. These were transported via secure courier to trust pathology labs. Any delays with sample collection were reported as incidents. There was one incident reported in the last 12 months that related to a delay in the collection of a blood sample.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Patients we spoke with were aware of the complaints process and how to raise concerns.

Staff understood the policy on complaints and knew how to handle them. Staff told us they dealt with informal complaints in the first instance. In the case of a formal complaint, the trust

had a policy for handling complaints and concerns. The policy stated complaints would be acknowledged within three working days and a full response would be made within 25 working days of receipt. Where this timeframe was not possible, then a letter would be sent to the complainant to inform them of the revised schedule.

Managers told us how they would investigate complaints and identify themes. Complaints data provided by the trust did not identify any made about the outpatient department at Wimpole Street from October 2018 to September 2019.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Compliments data provided by the trust did not identify any made about the outpatient department at Wimpole Street from October 2018 to September 2019.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

The service demonstrated they responded to informal patient feedback by making improvements

to the service offered. This included all staff receiving customer care training in 2019. Staff could give examples of how they used patient feedback to improve the quality of care they provided. This ranged from ensuring patients had clipboards to fill out any forms, to providing sports wipes for cleanliness, as well as adding televisions to waiting areas, improving Wi-Fi access instructions and giving patients who had been fasting sandwiches.

Are outpatients services well-led?

Good

This was our first time inspecting this service. We rated well-led as **good.**

Leadership

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

The nurses and healthcare assistants were managed by the clinical nurse manager, who in turn reported to the general manager of the site. The general manager reported to the managing director of private patients across the trust, who was part of the executive team reporting to the chief executive.

The local leadership team had good knowledge of the service, with a clear understanding of the risks and challenges the service faced. They represented the service across the trust and shared information by attending trust wide meetings. They supported staff to develop their skills and take on more senior roles where they could, with the clinical nurse manager having been promoted into the role in the last 12 months.

Leaders demonstrated good leadership across the clinical areas, and all staff we spoke with on the wards recognised who they were. The managing director of private patients held quarterly breakfast mornings on the site to enable staff to drop in and talk to him about anything they wished.

Staff told us they were well supported by their leadership team, who were open to new ideas and suggestions. Nursing staff were positive about the clinical nurse manager, who was supportive and involved in their clinical decision making. Leaders told us they were proud of their staff who worked hard to deliver high quality care for patients.

Vision and strategy

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

The trust wide vision was: 'To be the UK's leading specialist centre for heart and lung disease, developing services through research and clinical practice to improve the health of people across the world.' This was supported by trust values, which were to be caring, respectful and inclusive to all patients, as well as believing in staff, being accountable, practising innovation and sharing knowledge.

The private patient division of the trust shared the same overall vision and values, but also looked at how it could support the trust's revenue streams, as all profit went back to the trust. The site was considering how to improve their appeal to private patients by offering a more flexible service with a greater range of specialties available under one roof. Collaboration and communication were put at the centre of the service's strategy going forward, with a focus of how to deliver this as part of building better relationships both 'inside and outside the four walls of the hospital'.

Most staff were familiar with the vision and values and how they related to their role in the organisation. The vision and values were included in the patient information packs and displayed on the website.

Culture

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

Staff expressed high job satisfaction and it was clear from talking with staff, there was a good working relationship between staff of all different levels. Staff we spoke with told us they felt supported, respected and valued within the teams they worked in. Nurses said they enjoyed their work. Staff attended monthly team meetings, which were well attended. Managers encouraged staff to provide feedback, and meeting minutes showed this feedback was discussed and considered.

Staff felt supported in their work and said there were opportunities to develop their skills and competencies, which managers encouraged. Staff told us they felt confident to raise any concerns with their line managers. There was an up-to-date trust policy on raising concerns, which outlined how to escalate any issues. Senior staff told us any errors were discussed openly and managed in a fair way, with an emphasis on learning. The trust had a 'freedom to speak up' guardian, whose role was to help staff to speak up about any issues to protect patient safety and improve the quality of care.

The service took part in the annual NHS staff survey. Results were not available for 2019 at the time of our inspection, but in 2018, Wimpole Street generally scored above the rest of the trust in most measures. A total of 29 staff answered the survey, with the majority of staff feeling support from their immediate line manager was good (79.3%), and that they worked in team with shared

purpose and objectives (86.2%). Of those surveyed, 90% felt they had good access to career progression opportunities and 93.1% felt the organisation acted on concerns raised to improve patient safety.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, there were no clear governance processes around the ongoing review of consultant's practising privileges.

Monthly meetings took place with all staff in attendance. Local information sharing took place, and these meetings fed into the trust wide governance structure. A senior member of staff from the Wimpole Street site attended the trust wide governance & quality committee. This committee, chaired by the medical director, was responsible for overseeing and managing the clinical risk, quality and safety agenda across the whole trust. This committee discussed trust wide issues, incidents, complaints and learning, ensuring lessons were shared, appropriate actions were taken relevant issues to raise to the trust board were identified. The governance and quality committee reported to the risk and safety committee, which was a sub-committee of the board.

Staff in the department had a good understanding of incidents, risk and local performance.

Three doctors were employed under practising privileges at the service. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work with an independent hospital. The practising privileges committee (PPC), chaired by the managing director of private patients, advised on matters relating to the granting and monitoring of practising privileges. However, the trust informed us the practising privileges applications of these consultants had been reviewed by members of the PPC remotely, not in a formal committee meeting. There had been no formal meetings of the PPC since the implementation of the committee in May 2018. The practising privileges policy did not include information on how practising privileges were reviewed, focusing instead on the granting of these privileges. This could present a problem if the numbers of consultants employed under practising privileges at the site increased.

Management of risk, issues and performance

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

We saw the local risk register, which referenced ongoing risks to the service, ranging from children being seen in the department to environmental concerns. These were graded with level of risk and reviewed regularly, with all being correctly graded as 'low' or 'very low' risk. Mitigating actions to minimise risk had been recorded against each item. The risk register was stored centrally on a shared drive.

We saw fire evacuation plans throughout the department and staff were aware of them. Site specific business continuity plans were available. Staff knew where to access these. Emergency evacuation chairs were installed within the building.

Hospital performance on key metrics, such as patient feedback and audit performance, was also shared on the drive, and emailed to staff as appropriate. A small range of local audits took place, with the resulting information shared amongst staff to promote improvement. We saw actions were taken from internal audit results.

Information management

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

Staff used the service's computer systems to access hospital policies and patient records. Each member of staff had their personal login information to access the

systems. During inspection, we saw staff logging off before leaving computers and we did not see unlocked computer screens. This prevented unauthorised access to data.

There was a shared drive and trust intranet available to all staff, which contained links to current guidelines, policies and procedures. All staff we spoke with knew how to access this and the information contained within. All staff had access to their work email, where they received organisational information on a regular basis, including clinical updates and changes to policy and procedures. Although there was no collated performance dashboard, audit and feedback results were shared with staff as required.

Information governance training for staff was part of the mandatory training programme and data provided showed 100% compliance of outpatient staff.

Engagement

Leaders and staff actively and openly engaged with patients, staff and local organisations to plan and manage services. However, response rates to patient surveys tended to be low.

Patient views about care and treatment were captured using a patient feedback survey. The service had been exploring ways in which to improve levels of patients completing these surveys, with a new shortened version of the patient feedback forms introduced in September 2019. This increased the response rate to 102 in October 2019, but this had fallen again in subsequent months. The service demonstrated improvements had been made on feedback received from patients, detailed elsewhere in the report. We saw examples of where positive feedback and comments made by patients were shared with staff.

The most recent staff survey results from 2019 were not yet available, but results from the 2018 staff survey showed the site generally scored better than the rest of the trust in most measures. In questions relating to 'equality, diversity and inclusion', the site scored 9 against the trust average of 8.9. In 'health and wellbeing' themed questions, Wimpole Street scored 7.1 against a trust average of 6, and 7.7 for 'immediate manager' related questions, against a trust average of 6.8. For 'quality of appraisals', the site scored 7.1 against a trust average of 5.8. 'Quality of care' scored 8.3 against a trust average of 7.9, with 'safe environment – bullying and harassment' scoring 8.3 against a trust average of 8. 'Safe environment – violence' scored 9.9 against a trust average of 9.7, with overall 'safety culture' scoring 7.8 against a trust average of 7.3. The overall morale of staff on site scored 6.1, which was the same as the overall trust score. The only measure scoring lower than the trust average of 7.5 was 'staff engagement', with the site scoring 7.3 overall.

As a result of the lower staff engagement score compared with the rest of the trust, staff ambassadors had been introduced across the private patient service. They were introduced to allow senior leaders to have a better understanding of staff needs, ideas and challenges. Monthly staff ambassador meetings took place, with the first managers' forum discussing topics such as appraisals, staff performance and training. In addition, staff told us about staff benefits such as flexible working hours and twice-yearly staff recognition awards.

Staff attended monthly meetings, designed to foster staff engagement, share information and drive forward improvement. We viewed minutes of staff meetings where staff were able to raise issues and discuss suggestions for improvement as needed. A monthly staff newsletter was emailed to all staff to ensure information was shared amongst all staff on site.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services, although no formal quality improvement training had been provided. Leaders encouraged innovation and new ideas.

The service encouraged staff to make suggestions for improvements to the service. Staff had not been formally trained in quality improvement methodology, but we saw an improvement project led by the staff ambassadors had been suggested, to streamline and digitalise forms that were currently paper based. We saw minutes from the staff ambassador forum indicating this project was being scoped, and asking each ambassador to go back and discuss with their colleagues any other ideas for improvement projects.

The service organised emergency scenario training sessions for staff across the site. The teams simulated different emergency situations of deteriorating patients during outpatient appointments. This exercise helped staff identify areas of learning. Staff told us the sessions helped them feel better prepared for a real emergency.

Good

Diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good

Are 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.

Data on training completion for diagnostics provided by the trust did not include a breakdown by staff groups using the standard staff groups therefore the data we saw covered all staff at the site. The trust set a target of 85.0% for completion of mandatory training.

Staff had training modules which included; prevent basic awareness, moving and handling load, information governance, infection control level two, fire safety, health and safety, moving and handling patients, adult basic life support.

For the period of October 2018 to November 2019, staff met the trust target for all modules except adult basic life support which had a completion rate of 80%. We were shown evidence that all staff had completed their intermediate life support training at the time of the inspection.

Advanced life support training had been completed by the two on-site clinical fellows and two allied health professional staff. This ensured coverage for patients suffering from acute critical conditions such as cardiac arrest and also encompassed life support training for children.

We saw evidence that showed all radiographer and technician staff were provided with training in relation to radiation protection, risks, protections and regulations.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse. Staff could identify their escalation policy.

The service used the trust safeguarding policy and followed the trust escalation processes which were appropriate for the safeguarding of adults and children. Staff were able to identify their safeguarding leads for adults and children and could access trust wide information through the intranet. Staff were able to tell us where and how they could access the safeguarding policies and were able to tell us how they would raise a concern.

Data on training completion for diagnostics provided by the trust did not include a breakdown by staff groups using the standard staff groups therefore the data we saw covered all staff at the site. The trust set a target of 85% for completion of safeguarding training.

Staff had training modules which included; prevent basic awareness, safeguarding children level one and two and safeguarding adults level one and two. For the period of October 2018 to November 2019, staff met the trust target for training compliance, with completion rates ranging from 87% to 100%.

Managerial staff told us that all staff members at the site were due to attend children safeguarding level 3 training in March 2020, we were shown evidence of this.

Good

Diagnostic imaging

We found that radiographers conducted identification checks complaint with IR(ME)R and the society of radiographers pause and check system.

The service had a chaperone policy and signs advertising this service were available to patients.

Cleanliness, infection control and hygiene

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

Cleaning services were provided by an external company through a service level agreement at trust level. Staff reported that there were no issues with the standard of practice by the external company staff.

We observed all areas of the service to be visibly clean and tidy. The imaging staff cleaned the imaging rooms at the end of each day. This was recorded on a daily check sheet which was reviewed by the manager each week. The external cleaning company cleaned each non-clinical area every day and a deep clean was conducted at regular intervals throughout the year.

We observed that equipment was cleaned on a regular basis and this was recorded on equipment cleaning records. We observed green 'I am clean' stickers on equipment, which provided assurances staff had cleaned the equipment.

Staff followed manufacturers' instructions and the service's infection prevention control (IPC) guidelines for routine disinfection. This included the cleaning of medical devices between each patient and at the end of each day. On the day of inspection, we saw staff cleaning equipment and machines following each use. We reviewed all machines in use and saw the machines had been disinfected where appropriate. Deep cleans using special cleaning products were done for clinical areas were done after seeing a patient that had contagious diseases or infections.

Hand hygiene audits were completed to measure staff compliance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene.' These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene to reduce risk of cross contamination between patients. Hand hygiene audit results for January to December 2019 showed a 100% compliance rate.

We saw evidence to show that cleaning audits were conducted on a weekly basis. The audits provided assurances that cleaning of the general environment where the external cleaning company operated was done to a high standard. The audit made notes of any discrepancies and reported these to managerial staff. For the period of October to December 2019 the results were generally between 95% and 100% compliance.

Environment and equipment

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

The layout of the centre was compatible with Department of Health - health building note (HBN06) guidance. There was a ground level reception area accessible by wheelchair, with a reception desk that was staffed during opening hours. The waiting area provided drinking water, light refreshments and toilet facilities for patients and relatives. We found toilet facilities for patients were clean and well maintained.

Staff had sufficient space in each room for scans and x-rays to be carried out safely. There were appropriate diagnostic imaging observation areas. These ensured patients were visible to staff during examinations.

During MRI scanning all patients had access to an emergency call alarm, ear plugs and ear defenders. There was always a microphone that allowed contact between the radiographer and the patient.

The imaging equipment was owned by the provider. All equipment conformed to relevant safety standards and was regularly serviced. For example, equipment met the requirements of the Ionising Radiation (Medical Exposure) Regulations 2017 (IRR17) Regulation 15. This sets out the general requirements in respect of all equipment, regardless of when it was installed and brought into clinical service. The service also met regulation 15(3) regarding testing of equipment.

Good

Diagnostic imaging

Equipment was tested before clinical use by the centre's radiographers. We saw evidence of monthly and annual quality assurance checks on imaging equipment as appropriate.

There were systems in place to ensure repairs to machines or equipment were completed and that repairs were timely. Any issues would be logged in a fault log by the radiographers, who liaised directly with the machine manufacturers. This ensured patients would not experience prolonged delays to their care and treatment due to equipment being broken and out of use.

The service had a formalised equipment replacement programme and servicing programme, which was in line with manufacturer guidance and risk assessed. The imaging equipment included an x-ray machine, PET-CT and MRI scanner all of which were relatively new and were purchased when or after the service opening in 2016.

We saw evidence that the site maintained an asset and equipment log as per the trust policy. The site log was part of a larger trust wide equipment log. All non-medical electrical equipment was electrical safety tested.

All relevant MRI equipment was labelled in accordance with recommendations from the Medicines and Healthcare products Regulatory Agency (MHRA). For example, 'MR Safe', 'MR Conditional', 'MR Unsafe'.

Resuscitation and difficult airway equipment were available, with evidence of daily and weekly checks to demonstrate that equipment was safe and fit for use. The resuscitation equipment was 'MR safe' and was marked as such. There were procedures in place for removal of a patient that became unwell whilst scanning was taking place.

Access to the imaging rooms was controlled by locked doors. There was signage on all doors explaining the magnet strength and safety rules, or radiation warnings and lights, as appropriate.

Room temperatures were recorded as part of the daily MRI checks. Staff who told us that where temperatures were not within the required range, the scanner would not work, and this would be escalated to the imaging lead and the service company.

We saw there was access in all areas to hand washing facilities, hand sanitiser and supplies of personal protective equipment (PPE), which included sterile gloves, gowns and aprons. All staff were bare below the elbows and used PPE where necessary. An audit was done for PPE compliance monthly, the results for January to December 2019 showed 100% compliance. Radiographer and technician staff, we spoke with told us that PET-CT equipment and environment was checked for contamination and damage daily by a named member of staff who logged their findings if there were any problems they would contact the medical physics team for advice.

We saw evidence of regular reviews and assessments undertaken as per the Control of Substances Hazardous to Health Regulations 2002 (COSHH).

Clinical and domestic waste was handled and disposed of in a way that kept people safe. Waste was labelled appropriately, and staff followed correct procedures to handle and sort different types of waste. Staff used sharps appropriately; the containers were dated and signed when full to ensure timely disposal, not overfilled and temporarily closed when not in use.

The service monitored radiation exposure to staff through monitoring badges which were sent for analysis to the medical physics team based at a neighbouring NHS trust who then sent it to an external company.

The Wimpole street site received 24-hour PACS (picture archiving and communication service) support for the trust PACS team based in the Royal Brompton site.

Assessing and responding to patient risk

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

The service ensured that the right person got the right scan at the right time, by following the recommendation from the Society and College of Radiographers to use a 'pause and check' system. This is a system of checks that need to be made when any diagnostic examination is undertaken. Radiographers used a three-point patient identification checking system.

All clinical staff were intermediate life support trained for both adults and children and the site had at least two staff on shift who were advanced life support trained. There were emergency alarms available across the imaging department, which we saw were operational. In

the case of an emergency such as a deteriorating patient, the team would stabilise the patient and check to see if the patient could be transferred to an appropriate inpatient setting at the Royal Brompton Hospital. If there were no beds available, the patient would be transferred to the nearest emergency department by ambulance.

The service had access to a paediatric crash trolley located on the first floor with grab bags on the second and fourth floors, which contained the appropriate equipment needed to resuscitate a child. The site always had two members of staff on duty that were trained in advanced life support (the training covered elements of paediatric life support), and managerial staff felt this mitigated the risk of the clinical fellows not holding European Paediatric Advanced Life Support (EPALS) training. All imaging staff held a Paediatric Immediate Life Support (PILS) qualification. Children and families had access to an exclusive waiting area.

Allied health staff conducting respiratory and cardiac stress tests had access to broncho-dilator drugs that were stored in locked cupboards in the treatment rooms. These drugs could be used to help patients breathe if they were having difficulties.

The radiation protection advisor (RPA) and medical physics expert (MPE) were provided by a local NHS trust as per the service level agreement for the radiology services for the whole trust. We saw evidence to show that the RPA and MPE were involved with the trust and the site on a regular basis. Managerial staff told us that they had joint meetings with the other trust imaging departments which the RPA and MPE attended. Radiographers told us that they had the contact numbers and email addresses of the medical physics department of the local NHS trust where the RPA and MPE were based and had no issues contacting them when needed. The service had appointed a radiation protection supervisor (RPS) for each area where needed.

Risk assessments had been conducted by the RPA and signed off by the imaging manger in relation to the generation and usage of radioactive substances. The risk assessments clearly identified hazards, risks, control measures and further actions. We saw that the risk assessments were last reviewed in 2018 and were not due to be re-reviewed until a significant change in practice occurred.

We observed there was appropriate signage and warning lights to make staff, patients and visitors aware of radiation areas and magnetic fields.

The service ensured that the 'requesting' of any type of imaging was only made by staff in accordance with IR(ME)R. All referrals were checked by an appropriate radiologist or the on-site clinical fellows as well as radiographers prior to imaging. We saw that all referrals included patient identification, contact details, clinical history and the type of examination requested, as well as details of the referring clinician.

Staff assessed patient risk and developed risk management plans in accordance with national guidance. For example, the unit used patient safety questionnaires for MRI and PET-CT patients. Patients referrals were checked by radiologists, clinical fellows and imaging staff for any potential safety issues that required further investigation. For example, whether the patient had any implants or devices where in such cases patients would be declined the scan until it was established with the referrer that these were MRI safe.

Staff assessed patient risk before administering contrast agents, patients were asked to complete a questionnaire where relevant medical history, allergies and if the patient was breast feeding was confirmed. All appropriate staff were trained in a professional cannulation course and the service had access to medications and equipment needed to deal with anaphylaxis.

Radiographers understood their responsibility to report any significant unintended or accidental exposure to ionising radiation. Managers knew that if exposure levels were too high, there was a requirement to report this to the CQC and Health and Safety Executive (HSE).

Women were asked verbally and had to sign a safety questionnaire regarding their pregnancy status. We saw that there were appropriate information leaflets and signs explaining the risk of radiation regarding pregnancy.

There were processes to escalate unexpected or significant findings. The reporting radiologist was contacted by a member of staff to advise them of the need of an urgent report to ensure it received prompt attention. All images would be sent to the referrer urgently. If at time of examination, the allied health professional staff thought the patient needed urgent medical attention, the patient was seen by the on-site

clinical fellows who would assess the patient and advise accordingly the service endeavoured to keep the patients within the care of the trust where appropriate, otherwise patients were advised to attend the nearest NHS emergency department or make an urgent appointment with their GP.

We found that the local rules were in compliance with ionising radiation regulations and there was evidence that they were reviewed at regular intervals. The employer's procedures were in compliance with IR(ME)R, and there was evidence to confirm staff had read these procedures.

Medical staffing

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

Medical staffing rates within diagnostic imaging at Wimpole Street were analysed for the past 12 months and there was not enough variation in vacancy, turnover, sickness and bank and locum use to comment on the performance of these metrics over time.

The medical staffing data we received from the trust for the site consisted only of the two clinical fellows as they were the only medical staff that were employed specifically for this site. For the period of October 2018 to November 2019; there was no staff turnover, sickness rate was 0.2% and the service had identified a 29% vacancy rate due to increasing demand

Most consultant staff attending the site were staff employed by the trust, there were a smaller proportion of consultant staff attending that were employed by honorary contracts as part of service level agreements with other local NHS trusts.

The service also employed two clinical fellows who were cardiologists by background, they were based at the Wimpole Street site and did not regularly rotate to other trust sites unless for personal development objectives.

.The site used a total of 40 hours of bank staff which was 2% of all available hours, no agency staff were used and there were no unfilled hours.

Radiographer staff reported to us that radiologists were easy to get in contact with as one would usually be on site during operational hours, otherwise they could be contacted by telephone or email.

Allied health professional staffing

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

Allied health professional staffing rates within diagnostic imaging at Wimpole Street were analysed for the past 12 months and there was not enough variation in vacancy, turnover and sickness rates over the last 12 months for allied health professionals to comment on the performance of this metric over time.

The allied health professional staff were a small workforce of 8.0 whole-time equivalent (WTE) at the time of the inspection, the maximum number of staff the core service had were 10.3 WTE. This meant there was a vacancy for 2.3 WTE posts. The vacant posts had been identified in accordance to service growth predictions.

Out of the 8.0 WTE posts, 6.3 WTE posts were filled by permanent members of staff.

The turnover rate for the core service was 15.8%, however this was caused by one permanent staff member leaving in the January to December 2019 period.

In the January to December 2019 period the agency usage rate for diagnostic imaging was 17%.

The service used an agency staff member to cover the role for PET-CT technician for a four-month period in 2019.

The service used one bank MRI radiographer to cover a role for 10 months during a staff secondment.

Managers we spoke with told us that the trust had active recruitment initiatives for allied health staff. Recruiting echocardiographers was difficult, however this was a sector wide issue. Turnover of this type of staff is usually high as staff move on for career reasons.

Records

Good

Diagnostic imaging

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

Patient care records were electronic and were accessible to staff. We checked a total of ten records and all records contained evidence of patient consent, general patient observations, dose given per procedure, aftercare advice given, images, radiologist report and relevant safety questionnaires. Patient records were kept in an electronic patient record system, images were kept on the picture archiving and communication system (PACS) and dose information was kept in the radiological information system (RIS).

Patients' personal data and information were kept secure. Only authorised staff had access to patients' personal information. Staff training on information governance and records management was part of the mandatory training programme.

Any paper records were sent to medical records in a sealed bag via courier. We saw that physiology staff kept data on paper in a locked drawer, staff told us that this was kept for one year before being archived and disposed securely.

The service mainly received referrals electronically, they were able to accept referrals by paper, but staff told us that verification from the referrer would be sought. Administrative staff explained to us that most referrals were from trust doctors or doctors working at local NHS trusts which were under a service level agreement. In cases were external doctors referred patients their credentials were verified by the administrative staff and the referral was checked by the clinical fellows or radiologists depending on the modality to verify if it met IR(ME)R requirements.

Any images or scanned documentation relating to the patients' scans were transferred to an electronic portal that was accessible by the referrer and the patient. This gave the referring consultant access to both the images taken and the radiologist's report. Patients had access to their images but could not access the radiologist report without the referring clinician.

Medicines

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

The service did not use any controlled drugs. The service maintained a log of all medicines administered by clinicians

The service stored refrigerated medicines within the manufacturer's recommended temperature ranges to maintain their function and safety. During the inspection we checked the medicines fridges and we saw records which showed staff had checked the fridge temperature daily. All temperatures recorded were within the expected range.

Patients were asked about their allergies, as part of the safety questionnaires in line with best practice guidance, prior to medicines or contrast being administered.

Allied health staff conducting respiratory and cardiac stress tests had access to broncho-dilator drugs that were stored in locked cupboards in the treatment rooms. These drugs could be used to help patients breathe if they were having difficulties.

All medicines and contrast agents were prescribed by appropriate medical staff before being administered. This was recorded on prescription charts and stored electronically.

We saw that appropriate staff held an administration of radioactive substances advisory committee (ARSAC) license for the administration of radioactive substances. The injection of the material was usually delegated to the technician staff who was in charge of conducting the scan, however due to the novel procedure the appropriate medical staff was on-site and available to provide assistance.

The trust conducted a "safe and secure handling of medicines audit" in November 2019 for the Wimpole Street site. This audit was done by a senior pharmacist that worked at the trust and was done to monitor compliance against the regulations. The audit highlighted some urgent actions regarding managers signing record logs, recording the variable fridge temperatures and ensuring drugs and intravenous fluids were stored in locked cupboards. During the inspection we observed that these actions had taken place.

Incidents

Good

Diagnostic imaging

The service managed patient safety incidents well. When things went wrong, staff apologised and gave patients honest information and suitable support.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2018 to November 2019, the trust reported no never events for diagnostic imaging at Wimpole Street.

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in diagnostic imaging at Wimpole Street which met the reporting criteria set by NHS England from December 2018 to November 2019.

The service had an incident reporting policy and procedure to guide staff in reporting incidents. Staff understood their responsibilities to raise concerns, to record safety incidents, and investigate and record near misses. Staff reported incidents using an electronic reporting system, and area leads ensured that incidents were investigated and discussed during governance and staff meetings.

We found there to be effective arrangements for any possible spillages or contamination in relation to radioactive substances. The service had policies in place and appropriate risk assessments had been conducted.

The duty of candour is a regulatory duty that related to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Staff we spoke with were aware of the duty of candour. There had been no incidents when statutory duty of candour had to be used in the 12 months prior to this inspection.

Are diagnostic imaging services effective?

Not sufficient evidence to rate

We do not rate effective for this type of service.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

The service followed guidance and policies were developed in line with the Health and Care Professions Council, Public Health England (PHE), Society of Radiographers, National Institute for Health and Care Excellence (NICE) guidelines and the Medicines and Healthcare products Regulatory Agency.

Safety alerts and NICE guidance were checked for by the trust governance team and were disseminated to relevant areas. Managers told us that they were reliant on consultant staff to bring specific modality related guidance to their attention. Guidance was reviewed by the governance team on the site to see if it was relevant to their practice. Non-manager staff were made aware of guidance through monthly staff meetings.

National Dose Reference Levels (NDRL) were based upon Public Health England 'HPA-CRCE-034: Doses to patients from radiographic and fluoroscopic X-ray imaging procedures in the UK (2010 review)'. We found that the doses given were audited annually. Doses for children had been checked and approved by the medical physics expert.

The service based its policies and procedures on the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 2017) and Ionising Radiation (Medical Exposure) Regulations 2000/2018. The local rules were up to date and reflected both equipment usage and the services localised practice. The local rules were on display.

The service had local rules based upon 'Safety in magnetic resonance imaging,' (2013), guidelines. We found the local rules provided clear guidance on areas relating to MRI hazards and safety and the responsibilities of MRI staff to ensure work was carried out in accordance with the local rules.

The service conducted local audits and peer reviews to check compliance with local polices and to identify areas of improvement. Audits included; infection prevention and control, image quality, medicine management, contrast agent reaction and PET-CT specific audits.

Nutrition and hydration

Good

Diagnostic imaging

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

Patients were provided with instructions about fasting before their scans, if appropriate. Patients with diabetes would be flagged at the referral stage. Staff told us they would monitor these patients to ensure they maintained a normal blood glucose level if they needed to be nil by mouth before their scan. Patients were provided with light refreshments and sandwiches after their scan if they had been fasting.

Patients had access to drinking water and a tea/coffee making machine whilst awaiting their examination. There were also light snacks available in the main waiting area.

Pain relief

Staff ensured that patients remained comfortable during their examination. The service could prescribe pain relief if needed.

Pain assessments were not undertaken by the imaging service directly. Patients managed their own pain and we were advised to continue with their usual medications. In circumstances where patients were presenting with pain and needed support, they could be seen by the on-site clinical fellows and be prescribed pain medication, however the service did not stock these medications and did not have an on-site pharmacy.

Patient outcomes

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

The service conducted local audits and peer reviews to check compliance with local polices and to identify areas of improvement. Audits included; infection prevention and control, image quality, medicine management, contrast agent reaction and PET-CT specific audits.

We found that the service conducted appropriate audits of their scanning and imaging practices to meet the "as low as reasonably practicable" principle set out in the Ionising Radiation (Medical Exposure) Regulations 2017 (IRR17) Regulation 12. The service conducted audits of its scanning protocols for PET-CT, where patient doses had been reduced by 60%.

We saw evidence to show that the service audited the number of rejected x-ray images. This was done to help limit any unnecessary radiation exposure patients received. We saw that the audit checked the number of rejected images per radiographer and noted the reasons. The percentage of rejected images was logged, the results showed that number of rejected images had decreased over time.

The service conducted a contrast agent reaction audit for patients seen between July 2017 and May 2019. The results showed that 0.56% of patients suffered a reaction to contrast agent at the service, this was better than the average of 1% the global scientific literature suggested.

We saw evidence of trust cross-site audits (including the Wimpole Street site) which aimed to check the consistency in assessing and reporting cardiac conditions (such as aortic stenosis) under echocardiogram guideline.

Allied health staff that we spoke with told us that audit results, effectiveness and outcomes were a regular discussion subject in staff meetings. We saw evidence of this in meeting minutes.

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. There was an induction and probation period for clinical staff during which clinical competencies were assessed.

There were arrangements in place for supporting new staff at the service, including an induction and probation period during which clinical competencies were assessed. Staff were required to complete a competency checklist within the first three months of employment and did not work until the required competencies had been met. This ensured all staff were competent to perform their required role. We viewed induction records for clinical staff, which included competency checklists. Staff that we spoke to were satisfied with the induction process and how it prepared them for their role.

Good

Diagnostic imaging

Staff we spoke with told us they could access development sessions at other trust sites. Monthly development sessions were provided in the form of 15-minute presentations by staff from differing modalities.

All radiographers had been trained in cannulation. Radiation protection and IR(ME)R update training was given by the radiation protection supervisor at location level.

Staff we spoke with told us that they were able to attend relevant external courses to enhance professional development and this was supported by the organisation and local managers. Radiographer staff told us that learning and development was a standing agenda item during appraisals and team meetings.

The trust supported extended roles for allied health professionals and we found that staff at the site were offered opportunities appropriate to the setting. For example, the PET-CT technician was trained to conduct general chest x-rays as part of role development. The technician was supervised by senior radiographers. The image quality of their work was audited by the area lead and compared to qualified staff. We saw evidence that the governance team and radiation protection committee had oversight of this role extension.

Radiographer staff were also offered cross-rotational posts between the different modalities which allowed them to gain competencies in MRI and PET-CT scanning. We were provided with an example where a new radiographer was supported to gain competencies in cardiac stress testing under the supervision of medical staff.

Allied health staff performance was monitored through peer review, with medical staff feeding back any development points or highlighting areas of good practice. We saw that the governance team also had oversight of this.

The trust had been moving to a different appraisal system and had some difficulties in collating electronic data centrally. However, we saw evidence of formal staff appraisals occurring annually and we saw evidence of the planned appraisal cycle. All allied health staff and administrative staff we spoke with at the service we inspected confirmed they received regular appraisals.

According the data we received in the period of October 2018 to September 2019, 62.5% of required staff in diagnostic imaging received an appraisal compared to the trust target of 80%.

Multidisciplinary working

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

Staff told us there was good teamwork between various professionals within the service. On the day of inspection, we observed good working relationships between all grades of staff and professional disciplines.

We saw evidence of joint imaging and physiology team lead meetings once per month. Senior staff from these two cohorts discussed the service, patient journey, issues, concerns, incidents and learning. Specific patients were also discussed if needed.

Radiologists and cardiologists that attended the site were employed by the trust and attended all relevant multidisciplinary meetings where patients and their cases were discussed. We saw evidence to show that physiology staff also attended relevant meetings to discuss their specific patients when needed. Radiographer staff did not attend these meetings due to the nature of their work.

The service endeavoured to provide all relevant diagnostics including imaging and physiological tests on the same day for patients, this required co-ordination between the different staffing groups and involved imaging, physiological, administrative, nursing and hospitality staff.

Seven-day services

Diagnostic services were available five days a week to support timely patient care.

The service was operational from 8am to 8pm, Monday to Friday. MRI and PET-CT scans were available until 6.30pm. X-ray and physiological diagnostics were available until 8pm.

Health promotion

Staff gave patients advice in relation to their procedure.

Good

Diagnostic imaging

There was patient information on diagnostic imaging procedures available on the service's website and in the waiting area and reception area.

Patients were provided with information on what actions they needed to take prior to their scan. For example, whether they should eat or drink anything, including amounts of fluid intake and the timescales for eating or drinking, or what to wear. Advice was also provided for patients suffering from claustrophobia and these patients were also offered dummy runs of scans, so they could get used to the environment.

We saw leaflets and posters that advertised services for general health conditions such as weight loss and smoking cessation

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Data on training completion for diagnostics provided by the trust did not include a breakdown by staff groups using the standard staff groups therefore the data we looked at covered all staff at the site. The trust set a target of 85.0% for completion of MCA/DoLS training. For the period of October 2018 to November 2019, all staff had completed their training.

We saw evidence that systems were in place to obtain verbal consent from patients before carrying out procedures and treatments. We observed staff gaining consent from patients before procedures took place. Staff we spoke with understood the need for consent and gave patients the option of withdrawing consent and stopping their scan at any time. The service did not use consent forms but did note verbal consent in patient records and collected signed safety questionnaires prior to scanning.

Where a patient lacked the mental capacity to give consent, guidance was available to staff through the trust consent policy. Staff we spoke with told us that patients lacking understanding or capacity to consent were not scanned or imaged until a discussion was held with appropriate medical staff. The service did not undertake scans or images until appropriate medical staff could confirm the images were in the patient's best interest. Staff told us that if family members were present they would be consulted and involved in the process.

Are diagnostic imaging services caring?

Good

We rated it as **good.**

Compassionate care

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

We observed interactions between staff and patients prior to, during and following procedures. Staff introduced themselves prior to the start of a patient's treatment, explained their role and what would happen next. Staff had a caring, compassionate and sensitive manner. The patients we spoke with were positive about the care they received and complimented the customer service of the patient co-ordinator staff.

Staff ensured that patients' privacy and dignity was maintained during their time in the service and during any scanning. Patients that chose to wear a gown during their scan stayed in the respective changing rooms, which were located close to the appropriate scanning rooms, whilst waiting for their scan.

There was a chaperone policy in date and patients were informed that they could have a chaperone present for their scan. A chaperone is a person who serves as a witness for both patient and clinical staff as a safeguard for both parties during an examination or procedure. All staff we spoke with understood their responsibilities in relation to chaperoning and offering this service to patients.

We saw the results of the patient satisfaction survey conducted for the Wimpole street site between March and December 2019. A total of 318 feedback forms were received which was a 35% increase from the same period the year before. The results showed that; between 92% and 98% of patients found the reception staff to be courteous, informative and prompt, between 96% and 99% of patients found the hospitality staff to be good or

exceptional, between 95% and 99% of patients found the clinical staff to be good or exceptional, between 97% and 100% of patients found theuy were treated with privacy, dignity and respect, between 95% and 100% of patients would recommend the service to family and friends.

Emotional support

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

Staff provided reassurance and support for nervous and anxious patients. They demonstrated a calm and reassuring attitude to alleviate any anxiety or nervousness patients experienced.

Staff provided reassurance throughout the examination process, they updated patients on the progress of their examination. An alarm was available within the MRI scanner to enable patients to speak to the radiographer at any time. Patients were advised that if they wanted to stop their scan, staff would assist them. Staff told us patients that stopped their scan due to anxiety or claustrophobia could discuss choices for an alternative appointment, such as having a friend or family member to act as support or staff would discuss coping mechanisms to enable the patient to complete their scan, such as having their own music playing, wearing eye-masks or choosing a radio station to listen to. Patients that were identified as claustrophobic prior to their appointment were offered a trial run where they could take their time to see the scanner and mentally prepare.

We observed staff provide emotional support to a patient undergoing a difficult PET-CT scan. Staff reassured the patient and treated them with kindness. The patient told us that they felt the staff understood the stress on the patient.

We observed staff conducting lung function stress tests to provide careful instructions to patients throughout the test and we noted that they provided extra support during difficult periods of the test when patients can be short of breath. Patients we spoke with regarding this felt reassured by the staff.

Staff allowed children to have extra time for their x-rays, they explained the procedure using simplified language and provided encouragement and reassurance throughout the procedure, parents were involved throughout the procedure to ensure children felt reassured.

Understanding and involvement of patients and those close to them

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

On the day of inspection, we observed that staff communicated with patients and their relatives in a way they understood. All patients were welcomed into the reception area, patients' needs were met by co-ordinator staff who could escort patients directly to the area they needed, clinical staff would reassure patients about their procedure. Patients were given enough time to ask questions and staff took time to explain the procedure and answer all questions in a calm, friendly and respectful manner.

Patients and relatives were given clear information verbally and in written form before the appointment. Patients were provided with aftercare advice following a scan and given an access code to view their images online.

Patients that were given contrast agents before scans were asked to stay in the waiting area or if they wished in the nearby area for at least 30 minutes. If patients were unwell during this time they were assessed by medical staff and usually transferred to a local NHS emergency department.

Patients that were given radioactive substances were provided with detailed information on how to safely manage themselves in their home environment and around others over the following days. Patients were given a support number to contact if they required any further information or help.

Are diagnostic imaging services responsive?

Good

We rated it as **good.**

Good

Diagnostic imaging

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of patients.

We found the environment of the service met the needs of its patients, there was enough seating available with access to light refreshments, entertainment and toilet facilities. We observed that there was a quiet waiting area available for children or families. There was adequate signage in English and Arabic for patients to find their way around. The service had access to a lift.

Patients were provided with information regarding their scan or procedure prior to attending and if they were walk-in patients with a valid referral letter from a healthcare professional, they were provided with information of paper as well as verbal explanation. Patients that had booked in advance could access information through the electronic portal.

The service employed patient co-ordinators who could liaise between different staffing groups and areas of the service, they were able to escort patients to the needed area and ensure the patient journey went smoothly and that patient needs were met.

The service also employed Arabic-speaking patient co-ordinators who could also act as translators. This staff group was important to ensure a smooth patient journey for overseas patients. They advised patients regarding the local area, liaised between the service and the patient's embassy and advised clinical staff on cultural and religious practices.

The service did not have a prayer room available and patients requiring a space to pray, or quiet area were given access to an available consulting room.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

All staff had completed the equality and diversity course as part of their mandatory training. Staff understood the cultural, social and religious needs of the patient and demonstrated this in their work.

Patients' personal preferences and needs were identified at the booking stage or at the time of the scan. Staff told us reasonable adjustments, such as extending appointment times and allowing relatives or carers into the imaging room could be made for patients with complex needs. Nervous, anxious or phobic patients could have a preliminary look around the department prior to their appointment to familiarise themselves with the environment and decrease anxiety.

Staff told us that they could turn down the lights or use the scanners mood lighting to help reduce anxiety for patients.

The service had access to on-site Arabic translators. For other languages the service had access to a telephone interpretation service used throughout the trust. We saw that some patient information had been translated into Arabic. Hospital signage was in English and Arabic.

Patients with reduced mobility could access the department as there was a lift and step free access into the building.

The service did not have access to a hoist, so patients seen at the service had to have reasonable mobility. The service did have access to some mobility equipment such as banana board which allowed patients to move from wheelchair to scanner couch. The service had bariatric (high weight) wheelchairs and the scanner couches were bariatric patient capable.

Access and flow

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

The diagnostic imaging department saw both NHS and private patients. The service primarily accepted referrals from NHS consultants working at the trust or at neighbouring NHS trust that had a formalised arrangement. Non-complex scans and x-rays were available for walk-in private patients with a valid referral form or letter. Referral forms were checked by radiographers except in the case for complex procedures such as PET-CT scans or cardiac CT scans, in which case a radiologist consultant or clinical fellow checked and justified the referral.

We saw evidence to show that service monitored and audited cancellations and non-attendance. One example we saw was of an audit for non-attendance of lung

function test patients. The audit found that most patients that did not attend were referred by an external consultant and the second highest rate was attributed to trust consultants that did not hold clinics at the Wimpole Street site. We found that the audit contained appropriate actions and conclusions. As a result, measures were put in place to facilitate clearer communication between the booking team, referrers and patients.

An audit was conducted of PET-CT patients scheduled between May and September 2019 which showed that in this period 50 patients cancelled their appointments with the main reason being failed diet preparation. The audit highlighted appropriate actions and was due to be re-conducted in 2020. Staff told us that as a result diet sheets had been simplified and also translated into Arabic.

Trust consultants were able to book scans for their patients by calling the service or sending an electronic referral form. External consultants could send the patient with a referral letter providing it contained all the suitable information. Otherwise, they would have to complete a referral form.

Waiting times for procedures were minimal at the service with the booking team telling us that the maximum wait for any procedure would be 48 hours.

Waiting times once at the service were usually short, if there were any delays staff would inform patients when they were checking in. Staff told us that patients usually were in the department for 30 minutes from checking in to end of imaging unless the procedure was more complex.

The trust had targets for report turnaround times; x-rays had to be reported on 24 hours post procedure at the latest and MRI, CT and PET-CT had to be reported on five days post procedure at the latest. Staff at the service told us that most reports were completed within 24 hours post procedure unless it required a specific consultant to report it. We were provided with data which showed performance for the trust, the Wimpole Street site and separate data for PET-CT procedures. The data showed the service was largely meeting trust target and had minimal breaches throughout the year.

Learning from complaints and concerns

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

During the inspection we found that the service had received one complaint in relation to this core service which occurred after the reporting period. The complaint was regarding a patient who was unhappy due being guaranteed all their diagnostic tests being carried out on the same day, this did not happen due to an unexpected IT failure at the site. We found the complaint to be appropriately investigated and found that conclusions and learnings staff found from the process to be in line with what we identified. We saw evidence of appropriate discussion and learning from this complaint and that the service responded to the complainant in a timely way.

We saw evidence in the form of meeting minutes to show that complaints were discussed in governance meetings and team meetings. The service had recently started to review informal complaints and comments received on review websites.

Patients we spoke to said they would know how to make a complaint, and we observed the complaints process advertised to patients in the reception area

Are diagnostic imaging services well-led?

Good

We rated it as **good.**

Leadership

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

The Wimpole Street site had a general manager, who reported to the trust's managing director for private care. The general manager line managed the diagnostic imaging manager. The diagnostic imaging manager was responsible for all diagnostic areas at the site including the physiological monitoring areas such as cardiac and respiratory stress testing.

Good

Diagnostic imaging

We were told by managers that diagnostic services had been restructured in 2019 and the role of the diagnostic imaging manager was a new one. Other changes included the service now having their own modality leads where as previously they were shared with the Royal Brompton Hospital site.

Medical staff at the site were overseen by the trust medical director, who worked closely with the general manger for the site.

Staff told us trust executive staff visited the site and conducted impromptu walk rounds. Staff felt they were generally approachable, but most non-manager reception, hospitality and clinical staff at the site told us they would hesitate to approach the trust chief executive as they found him not as open as other senior staff.

Non-manager staff told us that local managers were supportive, approachable and had open door policies.

Vision and strategy

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

We saw evidence that showed the diagnostic service to have an appropriate business strategy which considered revenue, commercial competition, performance, the patient pathway and ways to grow. Due to the strategy being commercially sensitive, we cannot comment in detail.

We found that the vision and strategy for the service was consulted with clinical staff. Feedback was taken from area leads and medical staff about how they felt the service should move forward. Staff were encouraged to bring new ideas and help formulate a strategy for growth.

Managers we spoke with told us that their goal was to focus on the service growth by pursuing new novel imaging uses for the PET-CT scanner, the service was also looking at extending opening times and being more flexible to patients. Longer term plans were to focus on brand consolidation, improving efficiency, continuing quality improvement and exploring innovative practices.

We saw evidence to show that strategy and goals were discussed, and progression monitored in governance and managerial team meetings.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us they had plenty of time to support patients. Staff told us they felt supported, respected and valued at both a local and corporate level. We observed good team working amongst staff of all levels, with collaborative ways of working embedded across the service.

All staff we spoke with which included medical staff, administrative staff, hospitality staff and allied health staff spoke positively regarding the working culture of the service. Staff described it as open, friendly and family-like. Most staff we spoke with felt that they were part of the trust, although some staff felt the service was more independent of the trust.

Equality and diversity were promoted within the service and were part of mandatory training. Staff told us there was a 'no blame' culture, with honesty and openness encouraged so learning from mistakes could take place.

Staff were happy with access to continuing professional development and training within the organisation. We saw examples of staff within the service who had been encouraged to take on appropriate developmental tasks.

Managers we spoke with seemed to have a sound understanding of their colleagues and a positive rapport.

Governance

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

The service had a clear and effective system of general and radiation governance and management. There was a clinical governance framework which aimed to assure the

quality of services provided. There were regular governance meetings and weekly managerial meetings where incidents, regulatory matters, complaints and risks were discussed.

The Wimpole Street site was accountable to the trust board and had to present to the board quarterly during board meetings and governance meetings.

We found there were regular radiation protection committee meetings held jointly as a trust with the different sites attending in person or through video link. These meetings were attended by the radiation protection advisor and medical physics expert based in a local NHS trust. The service also conducted localised radiation governance meetings and the RPA and MPE attended these meetings where necessary. Discussion, learnings and outcomes from radiation protection meetings were reported to the trust clinical governance meetings twice a year.

We found that medical staff working at the site were usually the trust's own medical staff, or they were employed through an honorary contract system where trust medical staff could endorse them. We were told by managers that there were no more than four consultants employed through practicing privileges, this route was only taken when consultants from the trust were unable to endorse the applicant (as they may be unknown to them) to receive an honorary contract. In such cases the applicant was interviewed by the general manager and the appropriate employment checks and documentations were conducted by the trust human resource department. A committee chaired by the medical director had to give its approval of the applicant. Practising privileges were offered at various levels ranging from consultation only to full practises administering treatments, we were told by managers that the human resource department was responsible for ensuring the correct checks were done on an annual basis. At the time of the inspection none of the consultants employed through practising privileges were practising beyond consulting except for one staff member who was also reporting on images which were subsequently peer reviewed by trust consultants.

There were weekly staff meetings and radiographer staff we spoke with had a good understanding of incidents, risk and local performance. We saw departmental meeting minutes which demonstrated discussion of incidents and learning.

Management of risk, issues and performance

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

Performance was monitored on a local level. Progress in delivering the service was monitored through key performance indicators (KPIs). The centre manager told us that KPIs were mainly based around report turnaround times, patient satisfaction, NHS patient waiting times and revenue.

The service outlined roles and responsibilities to managing and decreasing risk related to patient care and the work environment in the health and safety policy. The service had a valid major incident and business continuity policy.

We saw the service's risk register, which was up to date and referenced ongoing risks. Risks were categorised into two subgroups; clinical and general. The risks were graded with level of risk and reviewed regularly, with appropriate actions taken to mitigate against them. An annual report on new and updated risks was discussed in the governance and staff meetings. Staff were able to tell us about their top risks which included; availability and generation of radioactive substances, welfare of children, revenue generation and staff professional growth. We found that risks staff had identified were in line with risks we had identified during the inspection.

An annual audit program ensured performance was monitored and managed consistently. Staff participated in local audits, with the resulting information shared amongst staff to promote improvement. We saw appropriate action plans from audit results, and evidence that improvements had been made.

The service had a substation to provide extra power to run MRI and PET/CT in case of a power failure; we saw evidence to show this system was tested for performance and reliability.

Good

Diagnostic imaging

Information management

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

All staff at the site had access to a shared drive and the trust intranet where they could access policies and procedures. Staff told us there were sufficient numbers of computers in the centre. Staff had individual logins to access the computer systems as and when they needed to.

All staff we spoke with demonstrated they could locate and access relevant information and records easily, enabling them to carry out their roles. Electronic patient records could be accessed easily but were kept secure to prevent unauthorised access to data.

Radiology reports could be reviewed remotely by referrers to give timely advice and interpretation of results to determine appropriate patient care. Patients and referrers could view images as soon as they were available through the online portal.

All staff had completed information governance training as part of their mandatory training.

Patients were provided with terms and conditions of the service as well as payment information, before booking a private appointment and once again on check-in.

Advertising and promotional material was in line with the professional guidance and legislation on healthcare advertising as set out by the advertising standard authority.

Engagement

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

Patient views about care and treatment were captured using a patient feedback survey. We saw evidence that informal comments were collated and fed back to staff in addition to this. Patient suggestions and comments were also collated as part of the survey and improvements in service were made as a result. For example, patients said they needed food after fasting for scans and the service was now providing them with a limited selection of sandwiches as they did not have a license to prepare food on-site.

Staff attended monthly departmental meetings, designed to foster staff engagement, share information and drive forward improvement. We viewed minutes of staff meetings where staff were able to raise issues and discuss suggestions for improvement as needed.

We saw for the 2018 staff survey for the private patients' directorate, the trust was unable to break down the information per core service. The results show that the private patient staff responded the same or more positively than the rest of the trust for all topics, however they scored lower for staff engagement. The survey covered; equality, diversity and inclusion, health and wellbeing, immediate managers, morale, quality of appraisals, quality of care, bullying and harassment, violence, safety culture and staff engagement.

The trust conducted employee recognition awards where colleagues could vote for each other and nominate individuals for excellent service. The local service replicated this and awarded coffee vouchers for any local staff that went above and beyond.

The trust operated a staff ambassador scheme which some staff from the Wimpole Street subscribed to. This scheme allowed the staff ambassadors to promote links between the trust sites and build working relationships. One of the staff ambassadors told us that this role now included doing cross-site quality improvement projects.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. The service promoted quality improvement and used novel diagnostic modalities.

The service used novel PET-CT imaging techniques to attain detailed images of the heart and respiratory system. The radioactive substances required for the scan were generated on-site and required significant expertise to set-up and run. The specialist cardiac PET-CT imaging conducted at the site was mainly used by NHS patients from the trust which was a tertiary centre with a national patient cohort. The modality was cost intensive and therefore not readily available throughout the UK.

Good

Diagnostic imaging

We saw evidence to show that staff undertook regular quality improvement projects. Examples for 2019 included; streamlining the booking process, improving the management of deteriorating patients, working with industry partners to improve the design of a cannula used by the trust and implementing customer service training.

Staff told us of a quality improvement project which was done in collaboration between radiographer staff and clinical fellow staff that directly affected patient care. Staff had noticed that there were failures at the point of cardiac sarcoid scans due to the stringent preparation required on the part of the patient where they had to fast for 18 hours and eat a special diet. Staff introduced a preparation programme which simplified information given to patients and provided extra support, this subsequently reduced the amount of failed scans which allowed for significant cost saving and a better patient experience.

Outstanding practice and areas for improvement

Outstanding practice

- The diagnostic imaging service used novel PET-CT imaging techniques to attain detailed images of the heart and respiratory system. The radioactive substances required for the scan were generated on-site and required significant expertise to set-up and run. The specialist cardiac PET-CT imaging conducted at the site was mainly used by NHS patients from the trust which was a tertiary centre with a national patient cohort. The modality was cost intensive and therefore not readily available throughout the UK.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should review it's practising privileges policy to ensure there is a clear and auditable process for timely review of practising privileges for the consultants that hold them.
- The provider should consider further ways to increase response rates to patient feedback surveys.