Inuvi Diagnostics Limited

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Inspection report

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

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

We did not rate this service. This is because the Care Quality Commission does not apply a rating to independent laboratory services.

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

We found:

- The service had enough staff to provide the right level of service. Staff had training in key skills and managed safety well. The service controlled infection risk well. Staff assessed risks, acted on them and kept good records. The service managed safety incidents well and learned lessons from them.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of their clients and end service users, and had access to good information.
- The service planned and provided a service that met the needs of the people using the service and those who referred people there. People could access the service when they needed it and received laboratory results quickly. People could provide feedback to the service to be used for quality improvement.
- Leaders had the skills and abilities to perform their roles and a good understanding of the services they ran. Staff felt respected, valued and supported. Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. Staff were clear about their roles and accountabilities.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical laboratories	Inspected but not rated	

Summary of findings

Contents

Summary of this inspection

Background to Inuvi Diagnostics Limited

Inuvi Diagnostics Limited was registered in 2019 and is an independent provider of pathology diagnostics services to people across the healthcare and wellbeing sectors. They offer pathology testing solutions across many disciplines including clinical biochemistry, immunology, haematology, endocrinology, microbiology, toxicology and virology. Such tests include, health and wellness checks (not in scope of CQC registration), thyroid function, liver and kidney, cholesterol and heart tests, as well as hormone, fertility, and sexual health tests. The service, within the last 12 months, has also conducted COVID-19 antibody testing. On 15 December 2020, the law changed. Coronavirus testing has been exempted as a regulated activity under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This means that any testing activity in relation to coronavirus has been taken out of scope of CQC registration. The new Coronavirus, Testing Requirements and Standards (England) Regulations 2020 require all private coronavirus test providers to become accredited by the United Kingdom Accreditation Service (UKAS).

At the time of inspection, the service had recently successfully transitioned from UKAS ISO 17025:2017 to UKAS ISO 15189:2012 accreditation. The United Kingdom Accreditation Service (UKAS) is recognised by the Government as the sole national accreditation body for medical laboratories.

The service is regulated to provide Diagnostic and Screening procedures and there is a registered manager in post.

How we carried out this inspection

The inspection team consisted of two inspectors and a specialist advisor.

During the inspection, we inspected the pathology laboratory using our comprehensive inspection methodology. We spoke with eight members of staff, including laboratory staff, registered manager, chief executive officer and other members of the senior management team. We reviewed a range of policies and procedures and audits as well as other documentation such as staff records.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We saw the organisation was a positive place to work and had truly embedded a culture of wellbeing and inclusivity for their staff.

The organisation invested time and resources to develop research in the field of postal capillary testing. This both supported their ambitions to become leading market sector specialists and provide evidence based research for the wider field of postal capillary testing.

Our findings

Overview of ratings

Our ratings for this location are:

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

Inspected but not rated

Medical laboratories

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

Are Medical laboratories safe?

Inspected but not rated

Mandatory training

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

All staff received and kept up-to-date with their mandatory training. Training topics were tailored to the individual roles within the service, core subjects included: general data protection regulation, health and safety, manual handling, whistleblowing and fire safety. Laboratory staff had acknowledged and read the policies and procedures relevant to their roles.

Managers monitored mandatory training and alerted staff when they needed to update their training. There was a policy for training and competency which included reference to recent United Kingdom Accreditation Service (UKAS) accreditations. At the time of inspection laboratory staff had completed the modules required for their role and were up to date with their mandatory training. Stress awareness and display screen equipment had been added the mandatory training three weeks before the inspection and staff were yet to complete these new modules. We saw each staff member had a training file with up to date policy acknowledgment and annual competency assessments.

Cleanliness, infection control and hygiene

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

The laboratory area and all non-clinical areas were visibly clean, well maintain and uncluttered. The service had suitable furnishings which were clean and well-maintained. Staff followed infection prevention and control principles including the use of personal protective equipment and we observed good practice by staff during the inspection. Personal protective equipment was readily available for staff.

Clinical hand washing facilities, coat pegs for hanging laboratory protective clothing and linen storage for clothing to be decontaminated was available. The service had a clear process for the decontamination of laboratory coats, and staff we spoke with were aware of this process. This included when laboratory coats required routine and additional decontamination.

There was a good supply of cleaning equipment such as sterile wipes, wall mounted hand gel and wall mounted paper towels throughout the service. Cleaning records were up-to-date and showed that all areas were cleaned regularly. This included the cleaning of temperature controlled sample storage areas.

There were spillage kits used to clean up spills of any liquid in the laboratory area. Staff showed us they could locate eye wash kits in the event of a chemical eye splash.

There were working protocols to make sure the risk of cross infection and contamination was prevented or minimised so far as was reasonably practicable. This included prevention of the spread of micro-organisms and contamination between specimens.

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 ensured it kept people safe. The laboratory was contained in a single storey converted unit in an industrial area ideally suited to the purpose of being a laboratory. The design of the environment followed national guidance such as the Department of Health; HBN15:Facilities for pathology services and this included aspects such as, the size, layout, security, clinical hand wash basins, staff changing and laboratory coat pegs. We saw clear boundary zones between the laboratory and the non-laboratory areas.

The service was expanding and was in the process of refitting a larger premise on the same industrial area with the intention of relocating later this year. This new space had provision for a clinical laboratory area as well as non-clinical areas which included a staff room, meeting spaces and offices. During our inspection staff were working across both premises.

Entry into the service was card operated and there were security cameras to the entrance of the industrial area.

Staff carried out daily safety checks of specialist equipment. There was an electronic quality management system including an equipment inventory that documented the name of the manufacturer, serial number, in use date, location, record of contracted maintenance and record of equipment breakdown. We saw all equipment noted on this inventory were within service date. The provider demonstrated each sample analyser was registered with an external quality assurance for performing the tests it was used for. Equipment is included in the scope of UKAS assessments to verify compliance with the requirements of ISO 15189. UKAS is the national accreditation body for the United Kingdom.

There was a safe system for the storage and disposal of specimens. Clinical waste was stored in lidded containers prior to it being transported to a safe secure locked container. Waste was collected weekly from a designated specialist waste collector.

Staff we spoke with were confident in the management of the control of substances hazardous to health and could easily locate guidance should additional support be needed.

Reagents and consumables that required temperature control were stored in fridges and freezers in the laboratory. All temperature controlled storage was monitored and recorded. Reagents and consumables at room temperature were stored appropriately in the stock room or near the analysers.

The service had a fire risk assessment conducted by an external provider in relation to up to date fire safety legislation in the last 12 months. The assessment showed some low and moderate risk and we saw ongoing action to rectify issues.

Assessing and responding to patient risk

Staff prioritised results where patients needed urgent medical attention and made sure they informed the person who requested the test as soon as possible.

Apart from COVID-19 antibody tests, most other tests were wellness checks and therefore did not require an urgent response. This meant the tests were self-referrals from people purchasing the tests through wellness services or referrals from independent GPs.

Staff knew about and dealt with any specific risk issues. There was a standard operating procedure to make sure unexpected or abnormal results requiring immediate or urgent medical intervention were communicated, processed and monitored in a timely way. Registered Health and Care Professions Council (HCPC) senior biomedical scientists oversaw the whole testing process and would authorise test results before being shared with the clients who would then contact the patient. If an abnormal result was flagged, it would be retested, and the client would contact the patient. This was in line with Key Assurance Indicators (KAI, 2019) for pathology service guidelines.

Laboratory staffing

The service had enough laboratory staff with the right qualifications, skills, training and experience to provide the right level of service. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave temporary staff a full induction.

The service had enough staff with the right skills to run the laboratory safely. Staffing levels met the Royal College of Pathologists key assurance indicator for senior staff. The laboratory was managed by a laboratory director, laboratory manager and deputy manager. The wider laboratory team consisted of an operations manager, a quality manager, senior biomedical scientists and medical laboratory assistants. The laboratory manager, deputy and biomedical scientists were registered with the HCPC.

The service employed consultant pathologists who were members of the Royal College of Pathologists and held substantive consultant level positions in the NHS. Cover was provided as part of their contractual agreements with the service. They were able to provide clinical advice and interpretation and supported the service with external quality assurance and internal quality checks. Their expertise was also used for signing off validations and verifications as well as reviewing policies and procedures.

The service ensured there was senior staff cover on every shift. Each senior manager had a nominated deputy who were confident and competent to manage issues in a manager's absence.

The service had procedures to make sure there was support and supervision of professionally registered (HCPC) staff in the service and this was through induction, appraisal, training, and competency assessments.

The service had a good recruitment system to enable relevant recruitment checks had been completed for staff. Disclosure and barring service (DBS) checks prior to staff starting had been completed, photographic ID and references along with annual qualification verification.

Inspected but not rated

Medical laboratories

Records

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

Records we reviewed were clear, contained detailed information and were accessible to staff. Information on specimen request forms were detailed and in line with the Health and Safety Executive's (HSE) requirement in relation to the provision of enough information on specimen request forms in clinical diagnostic laboratories.

Records were stored electronically and securely in line with Data Protection Act 2018 and RCPath (2015) guidance on the storage and retention of pathological records and specimens. Electronic records were accessible by authorised staff.

Results were reported electronically and were usually available immediately upon validation and authorisation. Electronic reports with detailed information was sent securely to the client. The service had arrangements for secure and frequent back-up of data.

Medicines

The service did not prescribe, administer or store any medications.

Medical reagents were stored safely, and batch numbers and expiry dates were monitored.

Incidents

The service managed 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 honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the service non-conformance reporting policy. The CAPA (corrective action/preventative action) model was used for incidents of non-conformity. This model was used to identify the causes of non-conformity so that corrective and preventative actions could be taken. This corrective and preventative action model was also used to review all other incidents and complaints. There were 35 open CAPA reports at the time of our inspection, all within the expected investigation and review of effectiveness plan timeframes.

There had been no serious incidents reported in the past year. Incidents were discussed in the monthly management review meetings as a set agenda item. Trends were analysed by the senior team every month and included monitoring of key performance indicators related to incident management.

We reviewed a selection of reported incidents and saw investigations had been made which included root cause analysis, remedial action, corrective action, preventative action taken, and that effectiveness follow up had been completed. Incidents were reviewed and closed by the Quality Manager.

There were evidence changes had been made as a result of identified learning and staff received feedback from investigation of incidents. Learning from incidents was shared through regular team meetings within the service, and minutes displayed for reading on accessible staff notice board for staff unable to attend.

Inspected but not rated

Medical laboratories

Are Medical laboratories effective?

Inspected but not rated

Evidence-based care and treatment

The service followed national guidance when presenting and interpreting results. Managers made sure staff followed quality control procedures.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Their policies were supported by standard operating procedures to provide up to date effective guidance for staff. The policies we reviewed were ratified and version controlled by the senior leadership team and referred to expert professional bodies.

The service had received United Kingdom Accreditation Service (UKAS) ISO 15189:2012 and displayed on their website which tests were and were not accredited. Senior staff we spoke with told us that they provided information to new or potential customers regarding the status of each test they required in accordance with ISO 15189:2012. Some clients were happy to request unaccredited tests, however all tests whether accredited or not were verified to meet the requirements of ISO 15189:2012.

There were internal and external quality control systems for ensuring intended quality was achieved. The service used several external quality assurance schemes including the United Kingdom National External Quality Assessment (UKNEQAS), WEQAS, DEQAS and LabQuality. There was a programme of regular audits and a programme of calibration of measuring systems and verification, so that results were traceable. Results of audits were used as part of their continued quality assurance of the service. We reviewed a selection of internal quality audits and saw when errors occurred actions were taken, and summary reports were run for overview from the leadership team. Internal quality controls were run daily at intervals throughout the day.

There was good oversight of technology and equipment used and the service invested in new equipment and technology if they knew this would improve the quality and effectiveness of the service.

Contracted consultant pathologists communicated any new guidance and they supported any review and implementation required.

Patient outcomes

Staff monitored the effectiveness of their service. They used the findings to make improvements and achieved good outcomes. The service used quality assurance schemes to monitor and check their results. The service had ISO151819 accreditation.

The service carried out a varied programme of repeated audits, both internal and external, to check assurance and improvement over time. They monitored the quality of service provision including health and safety requirements and guidance set out by the relevant professional bodies.

In certain cases, the laboratory rejected samples if the sample fell short of quality, volume or other criteria. This could be rectified by the sample being taken again.

Medical laboratories

There were standard protocols for any external quality assessment that did not show a satisfactory result. Returned results were viewed by the biomedical scientist and then escalated to the senior management team for sign off. The returned results were also reviewed at consultant level. We reviewed a sample of external quality assessment results and saw the summary report with steps taken for those results that required further action.

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 the service. The service had a training and competency policy for all staff, permanent and temporary.

All biomedical scientist staff had active registration on the health and care professions council register.

Managers supported staff to develop through yearly, constructive appraisals of their work. During these meetings staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. This meeting also included a full check of an individual's competence to perform their role. There was an annual training and competency review template for documenting staff appraisals.

Managers gave new staff an induction tailored for their role before they started and issued a training plan. We spoke with a new member of staff who explained the comprehensive induction programme they had completed. All staff we spoke with understood their role and responsibility within the team.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. There was a commitment to training and education within the service. Staff told us they were encouraged and supported with training and there was good teamwork. Staff were encouraged to keep up to date with their continuing professional development and there were opportunities to attend external training and conferences. We checked four staff personal training records. They all included a completed induction checklist, acknowledgement that all relevant policies had been read and understood and evidence of continued professional development within the last 12 months. We also saw incident reflections completed in one file.

Multidisciplinary working

Staff worked with other providers' teams to benefit patients. They supported each other to provide a good service.

The service held formal laboratory staff meetings when required and at minimum every three months. and used this time effectively to discuss provision of service and any barriers to achieving this.

The service had close working relationships with their clients, and worked collaboratively to ensure the end user received a high quality service. Engagement meetings were conducted weekly for the service's larger client organisations.

Inspected but not rated

Medical laboratories

Are Medical laboratories responsive?

Inspected but not rated

Service planning and delivery to meet the needs of the local people

Managers planned and provided services in a way that met the needs of the clients and end service users they served. It also worked with others in the wider system and local organisations to plan services.

Managers planned and organised services, so they met the changing needs of the local population. The provider offered a wide range of blood and urine tests from routine core profiles to specialist analyses on a private basis. Most of the non COVID-19 testing was for wellness blood checks.

During the height of the COVID-19 pandemic, the laboratory workload and capacity expanded to provide support to the Department for Health and Social Care for COVID-19 capillary antibody sample testing. The service provided a flexible and responsive service to accommodate this additional testing. This testing ended in April 2022. Although the Care Quality Commission does not regulate this activity, it is recognised the flexibility and work required to have provided this service.

The provider had undergone rapid growth within the past year and had planned for future growth with the expansion of the premises to accommodate a larger laboratory.

The process of testing was made simple from start to finish. We saw the testing kits had instructions that were easy to follow and applied consistent capillary testing methodology.

Access and flow

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

Most tests were processed the day they arrived in the laboratory. There were turnaround times for each test which were displayed in the guide for laboratory users. All tests with UKAS ISO1589 accreditation had a 24-hour turnaround time. Other non-accredited tests were available with turnaround times from 24 hours to nine days. Most tests completed were not of an urgent nature.

The turnaround times for results were closely monitored through monthly governance meetings and displayed via a key performance indicator dashboard. Information we reviewed showed from June 2021 to May 2022, on average turnaround times were achieved 98.63% of the time. When the provider experienced difficulties with access and flow they made alternative arrangements to ensure tests were actioned quickly.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included the person who made the complaint in the investigation.

Staff understood the policy on complaints and knew how to handle them. Managers investigated and responded to all complaints and routinely monitored them to identify themes and any emerging trends. Acknowledging receipt of a formal complaint was made within three working days with a completion of investigations and a response within 30 days.

Inspected but not rated

Medical laboratories

The service had received three complaints in the previous 12 months, complaints were reviewed as part of the service monthly governance meetings. We saw no outstanding actions for improvement.

Are Medical laboratories well-led?

Inspected but not rated

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

There was a management structure with clear roles and responsibilities to provide a sustainable high quality service. Specific to the laboratory was a laboratory manager who had responsibility and management of the laboratory and laboratory staff. The laboratory manager reported to the laboratory director who was part of the senior leadership team.

Leaders had the skills, knowledge, experience and integrity to run the service and had a commitment to their staff and each other. Leaders understood the challenges to quality and sustainability and could identify the actions needed to address them. All staff we spoke with told us leaders were visible and approachable.

The leadership team were knowledgeable and passionate about the service. They were visible and approachable. They were proud of the efforts of staff and their commitment to the business during the extreme circumstances of the pandemic.

All staff we met said they felt valued and part of the team and were proud to work in the team. They felt supported by the management team and their colleagues. We received positive feedback from staff who had a high regard and respect for their managers.

Managers encouraged learning and a culture of openness and transparency. Staff were supported to develop their skills and competencies within their roles.

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 provider had recently rebranded which included new values to better reflect the service. The vision, values and strategy had been developed using a structured planning process in collaboration with staff and key stakeholders. The new values had evolved from the service's previous values and included distinctive, authentic, collaborative, agile and impactful.

The senior leadership team talked passionately about embedding these new values, and using them as the foundations of the annual appraisal process. As these values were new, they had not been shared with the whole team, but there were plans to communicate them with the workforce.

The service had ambition to become market leaders in postal capillary sample testing, and use expansion to support development of postal testing for NHS specialties such as oncology and renal services.

Inspected but not rated

Medical laboratories

Culture

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

All staff told us they enjoyed working for the service and felt proud to be a part of it. There was a sense of teamwork, camaraderie, and shared values. Staff felt respected and valued.

The service had an open culture and staff told us they would not hesitate to report concerns to managers and believed these concerns would be taken seriously and acted upon with integrity and sensitivity. The organisation encouraged openness and honesty throughout all levels of staff.

Staff development was understood and encouraged. Training opportunities were available for all staff. Staff told us how they were supported by the senior leadership team to embark on the medical laboratory assistant training. Staff received an annual appraisal and regular check ins to provide a formal meeting to discuss development needs.

Wellbeing and appreciation of staff efforts were recognised. There was an emphasis on the safety and wellbeing of staff in the service. Staff had access to a number of incentives which included medical insurance, access to mental health, bereavement and financial counselling, wellness blood tests, re-imbursement of dental, eye care and therapy costs and group life insurance. Staff we spoke with talked positively about work social events, with the most recent BBQ a success.

The senior leadership team were conscious of the current cost of living crisis and how this has or might impact their staff. Various plans of help were in discussion and a support scheme had recently been communicated to staff.

All staff promoted equality and diversity within the workplace and we saw staff with protected characteristics were supported.

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.

There were effective and efficient structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services.

All levels of governance and management functioned effectively and interacted with each other**.** There was a clear performance management reporting structure with regular governance meetings looking at operational performance. We reviewed a selection of quality management system review meeting minutes and found good representation from staff of all levels including the senior leadership team. Areas covered within these meetings included audit outcomes and quality indicator analysis, assessment of user and staff feedback, external review reports, risk management and incident review. Actions with time frames were set against an item that required follow up and we saw these were continually monitored and reviewed each month.

Staff at all levels were clear about their roles and understood what they were accountable for, and to whom.

Inspected but not rated

Medical laboratories

Management of risk, issues and performance

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

The organisation had a clear and effective process for identifying, recording and managing risk. We saw the use of an electronic system for recording risks on a risk register and evidence the provider regularly reviewed and acted on the laboratory risk register. All identified risks had control measures and review dates documented. There was alignment between recorded risks and how staff viewed risk in the organisation.

There were processes to manage current and future performance which were reviewed and improved through a programme of clinical and internal audit. Leaders monitored quality, operational and financial processes and had systems to identify where action should be taken. Reports demonstrated action was taken when required and improvements made were monitored.

The organisation had a business continuity plan that reflected actions to take in response to untoward events effecting service delivery such as information technology disaster recovery or resource loss. The plan included clear levels of emergency and associated escalation plan.

Information Management

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

Information was used to measure improvement, not just assurance. Quality and sustainability both received coverage in relevant meetings at all levels.

Staff had enough access to information and challenged it when necessary. The service used a quality management system that supported the management of quality, risk and safety. Clear performance measures were reported and monitored through governance meetings. When issues were identified, information technology systems were used effectively to monitor and improve the quality of service provided.

The service had a quality manual describing the quality management system and how it meets the requirements of ISO15189 and appropriate national and international standards. This manual was linked to all policies and we saw this arrangement provided assurance data of notifications submitted to external bodies as required. There were also arrangements (including internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards.

The laboratory manager ensured the equipment was effective and appropriate for the service through calibration and certification of assurance.

Staff had received training on information governance and cyber security and were supported by policies in relation to confidentiality and information governance and data protection, which was in line with The Data Protection Act 2018.

The service employed an external data protection officer who supported the service to keep updated with best practise, provide guidance for policy review and advise on data breach requirements.

Engagement

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

Views and experiences were gathered and acted on to shape and improve the services and culture. This included the providers who had contracts and service level agreements with this service. There was transparency and openness with all stakeholders about performance. Managers told us how they used their specialist clinical knowledge about failure rates in certain test types and their recommendations for alternative testing solutions.

Staff were also actively engaged, including those with a protected characteristic, so their views were reflected in the planning and delivery of services and in shaping the culture. Engagement was through a variety of means, such as, staff meetings, emails, information on display boards and staff surveys. Staff felt empowered to make suggestions for quality improvement.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Leaders and staff aspired to continuous learning, improvement and innovation. This included participation in recognised accreditation schemes. The provider achieved the internationally recognised ISO 15189 accreditation.

We saw continuous improvement was a standing agenda item on the monthly quality management system review meeting. There was documented progress against recent change forms raised including target date and evaluation.