# The London Heart Centre Ltd

## Quality Report

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

## Ratings

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

## Overall summary

The London Heart Centre Ltd is operated by The London Heart Centre Ltd. The centre opened in 1978 and has been managed by The London Heart Centre Ltd since 2007. The service offers diagnostic tests for adults aged over 18 years.

Patients are offered electrocardiogram (ECG), stress echocardiography (stress echo), 24-hour blood pressure monitoring, Holter monitor, 14-day heart monitoring, exercise test, transthoracic echocardiogram and contrast echocardiogram services.

The service had two diagnostic imaging rooms in the basement and a consultation room on the ground floor.

We last carried out an announced focused comprehensive inspection of the service in November 2018. The service was rated inadequate for safe and well-led and good for caring and responsive. The service was judged to be inadequate overall and placed under special measures.

We re-inspected this service using our focused comprehensive inspection methodology. Our inspection

# Summary of findings

was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. We spoke with two patients and five members of staff, including consultants, a cardiac physiologist, senior managers and a receptionist. We observed two episodes of care and treatment and reviewed six care records. We reviewed a range of equipment including emergency equipment and diagnostic devices. We also reviewed the service performance data.

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

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

**Services we rate**

Our rating of this service improved. We rated it as **Good** because.

- Our rating of the service had improved. We rated it as good because the service had taken note of concerns raised about the service at the previous inspection and made improvements in the areas of mandatory training, effective leadership, policies, audits, appraisals, oversight on the risk register, risk assessments, recruitment process leadership, engagement and governance. However, further improvement was identified in the management of incidents, duty of candour, governance process and engagement with the public and stakeholders.
- 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 majority of staff received up-to-date mandatory training. The overall compliance for all staff was 87% which was better than the providers own target (80%).
- 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.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service used systems and processes to safely prescribe, record and store medicines.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Doctors and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- 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.
- People could access the service when they needed it. Waiting times from referral to the diagnostic tests were in line with good practice.
- Leaders had the integrity, skills and abilities to run the service. They were visible and approachable in the service for patients and staff.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

# Summary of findings

- 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.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.
- Leaders and staff actively and openly engaged with patients and staff to plan and manage the service.
- At the last inspection, there was lack of oversight on quality and effectiveness of the services, clinical policies, audits, managing of information and staff recruitment process. During this inspection, we found improvement and the service had addressed the issues and now had processes in place to continually improve the quality of service provided to patients.

However:

- Although staff knew what incidents to report and how to report them, the managers did not investigate incidents thoroughly. Some staff we spoke to did not understand the legal duty of candour.
- Although the service provided mandatory training in key skills to all staff, there was no robust system in place to ensure everyone had completed it. The service did not have a ratified mandatory training policy in place for staff.
- Although there was improvement in the governance process and the current governance structure had recently been initiated, the governance structures were not yet sufficiently embedded to give assurance that it would provide a robust framework of governance.
- Although the service now had up to date policies in line with national guidance, some policies were not yet in place in the service such as did not attend (DNA) appointment and turnaround time of diagnostic tests.
- The service did not have access to an interpreter for patients whose first language was not English.
- Although the service had improved on managing complaints and had complaints leaflets accessible in the waiting room, there were no posters prompting patients on how to make a complaint or raise concerns.

**Nigel Acheson**

**Deputy Chief inspector of Hospitals (London and the South East)**

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Diagnostic imaging** | Good | We rated the service as good:<br>Our rating of the service had improved. We rated it as good because the service had taken note of concerns raised about the service at the previous inspection and made improvements in the areas of mandatory training, effective leadership, policies, audits, appraisals, oversight on the risk register, risk assessments, recruitment process leadership, engagement and governance.<br>However, further improvement was identified in the management of incidents, duty of candour, governance process and engagement with the public and stakeholders.<br>. |

# Summary of findings

## Contents

Good

**Services we looked at**

Diagnostic imaging

# Summary of this inspection

## Background to The London Heart Centre Ltd

The London Heart Centre Ltd is operated by The London Heart Centre Ltd. The centre initially opened in 1978 and was taken over by The London Heart Centre Ltd in 2007. The service offers diagnostic tests for adults aged over 18 years. The centre primarily serves the communities of greater London. It also accepts patient referrals from outside this area.

The service has had a registered manager in post since 2013. The current registered manager was due to retire on 30 June 2019 and the clinic had a new manager who was in the process of registering with CQC as the new registered manager during inspection.

## Our inspection team

The team that inspected the service comprised a CQC lead inspector and a specialist advisor with expertise in diagnostic imaging services.The inspection team was overseen by Terri Salt, Interim Head of Hospital Inspection.

## Information about The London Heart Centre Ltd

The London Heart Centre Ltd is operated by The London Heart Centre Ltd. The service offers diagnostic tests for adults. Patients are offered access patients are offered access to electrocardiogram (ECG), exercise stress test, echocardiogram, dobutamine stress echocardiogram, exercise stress echocardiogram services that help with diagnosis and management of heart conditions.

The service is registered to provide the following regulated activities:

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

The centre had two diagnostic imaging rooms in the basement, and a consultation room on the ground floor. The service had two ECG machines, exercise treadmill test machine, echo machine, 24-hour ECG and blood pressure monitoring kits and an arrhythmia monitoring kit.

During the inspection, we spoke with five staff including; medical staff, reception staff and senior managers. During our inspection, we reviewed six sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected in November 2018 where the service was rated inadequate overall and placed under special measures.

Activity (June 2018 to June 2019)

- In the reporting period June 2018 to May 2019 there were 1,712 patient attendances recorded for diagnostic tests.

Four cardiologists, two cardiac physiologists, two receptionists, the registered manager and new clinic manager worked at the service.

Track record on safety:

- No Never events
- No serious injuries
- No formal complaints

# 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?

Requires improvement 

Our rating of safe improved. We rated it as **Requires improvement** because:

- Although we found the service largely performed well on and had taken note and improved on safety concerns raised at the previous inspection in the areas of patient record, health and safety risk assessment, infection control and mandatory training. However it failed to meet the full legal requirement relating to governance around incidents and mandatory training meaning we could not give safe a rating higher than requires improvement.
- Although staff knew what incidents to report and how to report them, the managers did not investigate incidents thoroughly. Some staff we spoke to did not understand the duty of candour.
- Although the service provided mandatory training in key skills to all staff, there was no robust system in place to ensure everyone had completed it.
- There was poor compliance in the completion of the duty of candour mandatory training. The service data showed that two staff had not completed the training and overall compliance was 60% which was below the organisation target of 80%.

However;

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- 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.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- 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.

# Summary of this inspection

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

## Are services effective?

We do not rate effective, however we found;

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Doctors and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

However:

However, some policies were not yet in place in the service such as policies on did not attend (DNA) appointment and turnaround time of diagnostic tests.

## Are services caring?

Good

Our rating of caring stayed the same. We rated it as **Good** because:

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

## Are services responsive?

Good

Our rating of responsive stayed the same. We rated it as **Good** because:

- The service provided planned diagnostic tests for patients at their convenience.

# Summary of this inspection

- 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. Waiting times from referral to diagnostic testing were in line with good practice.
- Although the service had improved on managing complaints and had complaints leaflets accessible in the waiting room, there were no posters prompting patients on how to make a complaint or raise concerns.

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

- The service did not have access to an interpreter for patients whose first language was not English.

## Are services well-led?

Good

Our rating of well-led improved. We rated it as **Good** because:

- Leaders had the integrity, skills and abilities to run the service. They were visible and approachable in the service for patients and staff.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action.
- 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.
- 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.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.
- All staff were committed to continually learning and improving services.
- At the last inspection, there was lack of oversight on quality and effectiveness of the services, clinical policies, audits, managing of information and staff recruitment process. During this inspection, we found improvement and the service had addressed the issues and now had processes in place to continually improve the quality of service provided to patients.

However:

# Summary of this inspection

- Although there have been improvements in the governance process and the current governance structure was recently been initiated, the governance structures were not yet sufficiently embedded to give assurance that it would provide a strengthened framework of governance.
- There was no system for the management, investigation and learning from incidents.
- The service did not actively engage with equality groups, the public and local organisations to plan and manage services.

# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| **Diagnostic imaging** | Requires improvement | N/A | Good | Good | Good | Good |
| **Overall** | Requires improvement | N/A | Good | Good | Good | Good |

Good

# Diagnostic imaging

| | |
|---|---|
| Safe | Requires improvement |
| Effective | |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |

## Are diagnostic imaging services safe?

Requires improvement

Our rating of safe improved.We rated it as **requires improvement.**

**Mandatory training**

- **Staff received and kept up to date with their mandatory training.**
- The service provided mandatory training in key skills to all staff via face to face sessions or e-learning modules. This included infection control, health and safety, information governance, fire safety, equality and diversity, duty of candour and safeguarding.
- Staff understood their responsibility to complete mandatory training and told us they were given protected time to complete their training.
- There was no system in place to ensure managers knew if staff had completed their training unless the staff files were reviewed. During inspection, there was no mandatory training matrix to show the staff overall compliance and the list of training staff were expected to complete. We reviewed staff folders and noted there was no index of the training that staff were meant to complete. The manager told us they were in the process of completing the mandatory training matrix, which was provided to us following the inspection.
- The service set a target of 80% for completion of all mandatory training courses. The service data showed an overall 87% compliance for all staff which was better than their target. Staff achieved 100% compliance for infection control, basic life support and all safeguarding training. Staff had met their target on all other topics with the exception of duty of candour which was 60%. Staff we spoke with confirmed their mandatory training was up to date. This was an improvement from the last inspection.
- Locum or temporary staff were required to provide evidence of mandatory training compliance from their employers before they commenced work.
- At the last inspection, the service did not have a mandatory training policy or document that set out what skills were required to perform individual tasks. During this inspection we noted that there was still no mandatory training policy in place for staff. Senior staff told us this was included in the service action plan and they were in the process of developing this.

**Safeguarding**

- **The service had clear systems, processes and practices in place to safeguard patients from avoidable harm, abuse and neglect that reflected relevant legislation and local requirements. Staff received training specific for their role on how to recognise and report abuse.**
- Staff had access to the service-updated safeguarding policy for adults and children which was in line with best practice and last updated in February 2019. Guidance in the policy included types of abuse, modern day slavery, discriminatory abuse, hate crime, FGM, forced marriage, protecting people at risk of radicalisation (PREVENT) and mental capacity.
- Staff we spoke to understood how to protect patients from abuse and the relevant organisations to report to and their contact details.

Good

# Diagnostic imaging

- Safeguarding was part of the service annual mandatory training and which included safeguarding adults and children1 and 2, and safeguarding adults and children 3. The overall safeguarding training compliance for all staff was 100% which was better than their target of 80%. This was an improvement on the last inspection.
- Since the last inspection the service had appointed one of the clinical directors as the named safeguarding lead for the service. Staff we spoke to reported good support from the safeguarding lead and their managers.
- Staff also liaised with other professionals and agencies such as GPs and their local clinical commission group safeguarding team for adults and children.
- The service reported there had been no safeguarding referrals in last 12 months.

**Cleanliness, infection control and hygiene**

- **All clinical rooms were clean and had suitable furnishings which were clean and well-maintained.**
- The service controlled infection risk well. Staff kept equipment, and the premises clean and tidy. They used control measures to prevent the spread of infection.
- Staff were responsible for cleaning the equipment and this was completed at the start and end of the shift and in between patients. The cardiac physiologists had a procedure for cleaning blood pressure cuffs prior to use on the patients which was documented regularly. This was an improvement since the last inspection.
- A contract cleaner was responsible for cleaning the building once a day between 6pm to 8pm.
- The May 2019 patient's satisfaction survey result showed that 94.4% patients felt the cleaning of the clinic was either very good or good and while 5.6% felt it was average.
- The service provided staff with personal protective equipment (PPE) such as gloves, to prevent and protect people from a healthcare-associated infection. We observed that clinical staff adhere to the clinic's 'arms bare below the elbow' policy to enable effective hand washing and reduce the risk of spreading infections. We observed posters on 'hand hygiene' were displayed in the clinic prompting staff and patients to wash their hands.
- There was access to hand washing facilities and hand sanitiser in all areas. We observed staff applying hand sanitising gel when they entered clinical consultation rooms. We observed the majority of staff disinfected their hands between patient contact, in accordance with national guidance (National Institute for Health and Care Excellence (NICE) Infection prevention and control: QS61).
- The service provided us with data on hand hygiene audits for the period of June 2019. We reviewed this data which showed it was an audit on the 11 steps hand washing assessment. The data did not show or include a comment if staff were fully, partial or not compliant during the assessment. There was no summary of findings, recommendation or action plan from the hand washing assessment document provided. Therefore, we were not assured an effective system was in place to give managers assurance staff were compliant in following the appropriate hand hygiene technique in line with best practice and how to address this if there were any concerns. Following the inspection, the provider told us the staff had been signed off as compliant in the hand hygiene assessment audit, however this was not recorded on the audit tool used submitted to CQC. Therefore, all staff were 100% compliant in the hand hygiene audit.
- There were contract arrangements in place to safely manage waste and clinical specimens. Waste was handled appropriately with separate colour-coded arrangements for general waste, clinical waste and sharps. We observed that general, sharps and clinical waste bags were changed frequently by staff. Staff used sharps bins appropriately and complied with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We observed that sharps containers were dated and signed when brought into use.
- The staff mandatory training matrix showed that staff had achieved 100% compliance on the infection control training against a target of 80%.

Good

# Diagnostic imaging

- The service had a plan in place for the influenza (flu) vaccination programme for staff to minimise the risk of cross infection. The staff folders reviewed, showed staff have had their influenza vaccination.
- The service had an updated infection prevention control policy in place that guided staff on infection control processes and procedures. This was an improvement from the last inspection.
- The service carried out regular legionella risk assessment checks and tests for all water systems in the clinic for the period of January 2018 to May 2019 in line with relevant regulations and legislations. The service also had a legionella certificate of registration which was valid until 31 September 2019.
- The service had also carried out a pest control test on 30 April 2019 and no concerns noted from the results.
- The service had not undertaken a cleaning and infection prevention and control (IPC) audit at the time of the inspection, however we noted this had been included in their current audit programme. Senior managers told us this audit would be carried out in August 2019.
- There was a spillage kit and a cleaning schedule in place for the clinic and environment.

**Environment and equipment**

- **The service had suitable premises and equipment for patients who accessed the service and maintained it well.**
- Access to the clinic was by means of an intercom buzzer system. Staff would call and escort patients from the waiting area to the clinical consultation room.
- The diagnostic imaging rooms were well-equipped and included couches and trolleys for carrying the clinical equipment required. There was stair lift access for patients to access the diagnostic rooms.
- There was appropriate emergency equipment in the clinic including resuscitation equipment and defibrillator. The service had systems to ensure emergency equipment was checked daily and during inspection we saw that staff were compliant with emergency equipment checks. We checked a range of consumable items from the resuscitation equipment and noted they were all in date. The emergency equipment and other equipment seen had all been serviced.
- Since the last inspection the clinic had bought two defibrillators an emergency trolley. The associate cardiologist was now responsible for overseeing the emergency medicines and equipment. This was an improvement from the last inspection.
- The disposable equipment seen in the clinic was all in date and appropriately stored.
- The diagnostic imaging rooms were in the basement and comprised of an electrocardiogram (ECG) and exercise treadmill test (ETT) room and a stress echocardiogram room. The service had two EGG machine and a stress echo machine, 24-hour ECG and blood pressure monitoring kits and an arrhythmia monitoring kit.
- Staff told us all equipment, including the stairlift at the centre, were serviced annually and maintained by a recognised service team. There was an effective system to ensure that repairs of broken equipment were carried out quickly so that patients did not experience delays to treatment.
- The service had processes in place to ensure equipment was maintained and tested for electrical safety, to ensure it was fit for purpose and safe for patient use. We saw that electrical testing of equipment had been carried out on 8 November 2018.
- Since the last inspection, the service had implemented a daily cleaning log of equipment. During inspection we saw that equipment were cleaned appropriately by staff. This was an improvement from the last inspection.
- The service had carried a health and safety risk assessment of the clinic in 15 January 2019. This was an improvement from the last inspection.
- The service was now registered to receive safety alerts from Medicines and Healthcare Products Regulatory Agency (MHRA). We saw that managers had shared safety alerts on a pace maker to staff. This was an improvement from the last inspection.

Good

# Diagnostic imaging

- At the last inspection we had concerns around the storage of waste, clinical equipment and medical consumables stored in cupboards in the corridors, and the patient changing room. We also had concerns around the wet floor in the shower which represented a health and safety hazard. During this inspection we noted that this had been addressed and there was no storage of waste and equipment in this area or health and safety hazard observed.
- We observed that all Control of Substances Hazardous to Health (COSHH) items in the clinic areas were locked and labelled appropriately to prevent or reduce staff and patient exposure to substances that are hazardous to their health. This was in line with the Health Regulations 2002.

**Assessing and responding to patient risk**

- **Staff completed and updated risk assessments to assess each patient during clinical appointments. They kept clear records and asked for support when necessary.**
- Patient assessments included past medical history and clinical indicators. We observed patient consultations during inspection and we saw that staff carried out patient identification, asked about patients' medical history and reviewed their previous echo report.
- The service had a policy for emergency management of cardiopulmonary resuscitation and a policy on communication of critical, urgent and unexpected significant cardiac findings that guided staff on process to take during these emergencies.
- Since the last inspection the clinic had contacted and liaised with the ambulance service to review the handover of care during an emergency. As a result, the clinic now had an approved handover of care plan in place which was now used during an emergency such as cardiac arrest.
- The service was in an outpatient setting and performed diagnostic imaging tests for patients with potential cardiac conditions. The service only performed non-invasive tests and did not see patients who had advanced heart failure. If a patient presented with an elevated risk they were seen by one of the experienced consultants or directors.
- During the diagnostic tests, patients were put under cardiac stress with exercise (on the treadmill) or with drugs (stress echo) and occasionally patients may become unwell. Since the last inspection the service had developed a written procedure for the management of a deteriorating patient. Staff told us that if a patient was unwell or collapsed they would call 999 for an ambulance. There was also a system on the staff computer desktop screens annotated by a 'green button'. If clicked, it would alert every active computer in the building of the medical emergency and its location. This ensured that all staff were made aware of the emergency. Staff told us they rarely had patient transfers to an acute NHS hospital, and only had one transfer in 20 years.
- The service had anaphylactic and other emergency medication available in the clinic for use during medical emergencies.
- At the last inspection there was no evidence of staff immunisation against hepatitis to minimise risk. During this inspection we saw evidence of clinical staff screening and vaccination against hepatitis B.
- The service had a lone worker risk assessment policy in place. We reviewed this document during inspection which stated it had been ratified at the clinical governance meeting on the 17 May 2019. However, we noted that this was not included in the clinical governance committee (CGC) governance meetings minutes on the 29 April or 29 May 2019. Although the health and safety meetings highlighted the policy had been completed, it did not indicate if it had been ratified.
- We noted that doctors were always on site for escalation in case of medical emergencies.

**Staffing**

- **The service had enough staff with the right qualifications, skills, training, and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- The service was staffed with two clinical directors, two consultants (conducted dobutamine tests), two secretaries, two managers, a cleaner, two

receptionists, two physiologists, a cardiologist and an associate cardiologist. Some of the cardiac physiologists and receptionists worked flexible hours or on zero hours contract.

- Consultants worked under practising privileges agreements. Under practising privileges, a medical practitioner is granted permission to work within an independent hospital. The directors were responsible for granting practice privileges. Consultants with practicing privileges had their appraisal and revalidation undertaken by their respective NHS trusts.
- A cardiologist attended the service daily to perform electrocardiogram (ECG) and stress echo. The cardiologists were substantively employed in the NHS and had a written contract with the clinic to deliver care to their patients.
- Regular agency staff were used to cover staff annual leave and the Friday clinics. The regular agency staff also had access to mandatory training.
- For the period of November 2018 to June 2019, the service reported a zero sickness rate and vacancy rate.

**Records**

- **Patient notes were comprehensive and all staff could access them easily. Records were stored securely**.
- The hospital used paper and electronic records to record patient needs and care plans, medical decision-making, reviews and risk assessments.
- On arrival to the clinic appointment, patients were asked to complete a private patient registration form with their details and payment method, either self-pay or private medical insurance.
- Paper records including the private patient registration form and the consent form were scanned into the system. We saw that patients' assessments and clinical records by the physiologist were scanned onto the electronic systems used by the cardiologist.
- Diagnostic imaging data was also stored electronically for reporting, reviewing and onward transmission to the patient GP or referring consultant. Staff told us these images were encrypted.
- We saw that staff stored paper and electronic records securely, and when electronic records were not in use staff logged off their computer to protect patient confidentiality. Staff used electronic patient records to record patients' diagnostic needs.
- At the last inspection, we had concerns around the breach of information governance as staff were using a generic log in to the clinical records system which did not provide a clear audit trail. During this inspection, we noted an improvement and all staff had their individual logins for the systems and therefore each member of staff had an electronic footprint in the system that could be traced to them.
- We looked at six sets of patient records during the inspection. Staff documentation on patients' records was concise, legible and written in accordance with the General Medical Council (GMC) record keeping guidance. There was evidence of discussion and collaboration with patients and staff. We saw evidence that staff carried our risk assessments and reviewed patients' past medical history and referral letters.
- Senior managers told us they had plans to commence patient record audits and this had been included in their audit plan in May 2019.

**Medicines**

- **The service had systems in place for the management, recording and prescribing of medicines in line with national standards and guidelines.**
- The service kept medicines for performing stress echo tests and for managing medical emergencies. These medicines were stored securely and in date. This was an improvement since the last inspection.
- The service had a doctor prescribed medicines policy and a medicines management that guided staff on recording, safe-keeping, handling, safe prescribing and disposal of medicines.
- The fridge and ambient room temperatures were monitored and recorded daily by staff and were within the required range to store medicines safely.

Good

# Diagnostic imaging

- Medicines were dispensed to patients prior to the stress echo tests and recorded in the patients' records. Staff kept a medicines log sheet with the details of the date, medicines dispensed, the quantity, name of the patient and prescriber.
- There were no controlled drugs kept or administered in the service.
- The service had a clear pathway and system in place to replenish consumables and avoid stock depletion. We saw that supplies were replenished frequently to avoid shortages and staff told us that they could request additional supplies if they were low before the next restock.
- The service used 'agitated saline' as a contrast medium for transcranial doppler, a non-invasive vascular ultrasound recording procedure that does not use ionizing and performed by the cardiologist. The service had an updated protocol for the procedure including how to prepare the agitated saline prior to intravenous injection. However, the protocol was not in a standardised document, did not include the date it was developed or if it had been ratified at the governance meetings.

**Incidents**

- **Although staff knew what incidents to report and how to report them, the managers did not investigate incidents thoroughly. Some staff we spoke to did not understand the duty of candour.**
- 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 November 2018 to June 2019, the service reported no incidents which were classified as never events for the service.
- In accordance with the Serious Incident Framework 2015, the hospital reported there had been no serious incidents which met the reporting criteria set by NHS England for the period of November 2018 to June 2019.
- The service used a paper system for reporting and investigating incidents, which was implemented in May 2019. Whilst there has been a slight improvement in the incident reporting culture there was no system in place for the investigation and learning from incidents.
- For the period of 20 September 2018 to 12 June 2019 there were six incidents reported in the clinic. The reported incidents related to information governance, near miss of diagnostic test requests, and results issued to the wrong patient, aggressive patients and waiting time.
- We reviewed the incident log book during inspection. Two of the incidents were reported using the new incidents form and while the other incidents had been reported to the manager via emails or typed document.
- The incident form included the incident details, immediate action taken and a comments section. The form was not comprehensive and was a one page form; it did not include a section for root cause analysis, investigation and learning from incidents. We saw an example of a medical emergencies reported on the incidents form and there was no analysis in the comment section, evidence of investigation, learning or action plan and recommendations. However, we saw that the incident was discussed with staff during the staff meeting.
- Staff we spoke with said they were encouraged to report incidents, and felt confident to do so. Staff knew how to report incidents and some of the staff we spoke with had reported an incident. Staff were able to tell us about the learning and changes to practice following two reported incidents on information governance. The service had updated their policy on scanning, uploading and sending information electronically as a result of recent incidents.
- 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, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service had a 'being open policy' which was in

place since February 2019 which described the duty of candour process. Not all staff we spoke to, understood the duty of candour requirement and its implication to clinical practice.

## Are diagnostic imaging services effective?

We do not currently rate effective for diagnostic imaging.

**Evidence-based care and treatment**

- **The service had systems in place to ensure policies, protocols and clinical pathways were reviewed regularly and reflected national guidance and legislations. The service used current evidence-based guidance and quality standards to inform the delivery of care and treatment to patients.**
- Policies and guidelines were available on the clinic shared drive and in hard copy format. The policies were updated and guided by the British Society of Echocardiography (BSE), Royal Colleges guidelines and National Institute for Health and Care Excellence (NICE) guidance. Staff told us they followed national and local guidelines and standards to ensure safe and effective care.
- At the last inspection we had concerns around the policies and guidelines which had not been updated for many years. At this inspection all policies reviewed were up to date and in line with national guidance and legislation, which was an improvement from the last inspection. However, some policies were not yet in place in the service such as policies on did not attend (DNA) appointment, mandatory training, turnaround time of diagnostic tests, sharps injury, caring for patients with dementia and learning disability and caring for bariatric patients.
- During inspection, we saw that the senior managers had engaged with the clinical staff to review some of the policies, guidance and pathways, such as patient confidentiality, complaints and consent, infection prevention and control (IPC), 'privacy/dignity/respect' and disposal of clinical and non-clinical waste to ensure they were fit for purpose and relevant to their practice. We saw that staff adhered to theses organisation policies and related national or professional guidance such as consent and respecting patient dignity.
- Since the last inspection, the service had implemented a 2019 clinical audit schedule which included audits on echocardiograms, infection prevention, hand hygiene, exercise stress test, , patient notes and medical devices. The service had completed audits on echocardiogram and hand hygiene and the other audits were to be completed before December 2019.

**Pain relief**

- **Staff used various pain tools such as the numerical rating scale to assess and monitor patients regularly to see if they were in pain in line with individual needs and best practice.**
- The cardiac physiologist and cardiologist discussed pain management during diagnostic tests and consultation as required.
- Patients we spoke to told us that their pain was assessed by staff during consultation and assessment. Patients were prescribed pain relief by the consultants if needed.

**Patient outcomes**

- **The service had carried out a local clinical audit. The service performed well in the clinical outcome audit and managers used the results to improve the service further. This was an improvement from the last inspection.**
- The service does not participate in national audits but had on-going plans to accredit the service to an external intelligence and quality improvement organisation with the aim to improve patient care.
- Managers had developed a comprehensive audit programme and some audits were due to be carried out within six months.
- The centre carried out an audit of the indication of transthoracic echocardiography (TTE) in May 2019 to assess the appropriateness of TTE in 29 patients that accessed the clinic in the previous month. A transthoracic echocardiogram is the most common

type ofechocardiogram, which is a still or moving image of the internal parts of the heart using ultrasound. The result showed that echocardiography was indicated and appropriate for the diagnostic tests on all the patients. The result showed indication of the following condition and assessment:

- 24% of patients indicated for atrial fibrillation, palpitation, syncope/presyncope,
- 21% had abnormal electrocardiogram (ECG)
- 17% of patients had hypertension
- 14% indicated for heart failure
- 10% indicated for pre-operative assessment
- 7% indicated for valvular heart disease
- 7% indicated for aorta assessment

We saw that managers used information from these audits to improve care and outcome.

- Each cardiologist reported on their diagnostic tests. Images were reported on in time order unless it was clinically urgent which would be flagged.

**Competent staff**

- **Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.**
- At the last inspection we had concerns about staff competency as there were no evidence of regular appraisals, practice privilege policy, current professional registration and indemnity insurance. During this inspection, we saw an improvement and all the concerns had been resolved.
- The service made sure staff were competent for their roles. Managers appraised staff's work and performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- All new staff and agency staff underwent an induction and orientation programme, which included mandatory training. We saw evidence from staff files that staff have had had their induction and were given protected time to read the organisation policies and staff handbook.
- Staff were supported by their managers to maintain their professional skills, competencies and experience through internal and external training, study days and career progression.
- We saw that all medical staff working or practicing under rules or privileges had completed their professional revalidation from the staff records reviewed. Consultants completed their annual appraisal at their individual NHS trust and kept up to date with their CPD) through regular attendance at training and seminars. The service now had a policy in place in the managing of practicing privileges and contracts for temporary staff.
- Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.
- Staff we spoke to had completed ambulatory ECG training to maintain their skills and competency. Staff had attended other training such as a dementia friendly training and mentorship course.
- Managers supported staff to develop their skills and competency through regular, constructive clinical supervision and one to one meeting of their work. This was an improvement from the last inspection.
- There were now processes in place for managing staff appraisals. The appraisal rate was 100%. This was an improvement from the last inspection.

**Multidisciplinary working**

- **Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.**
- Staff of different grades worked together as a team and with external professionals such as GPs to improve patient care and outcomes. Doctors and other healthcare professionals such as the cardiac physiologist and receptionist supported each other to provide good care.
- We saw there was good liaison and collaborative working between the multidisciplinary team (MDT) which was evident in the patient notes reviewed. We also saw examples where staff had liaised with the patient's GP or external cardiologist following a referral and diagnostic tests to improve patient outcome.

Good

# Diagnostic imaging

- All staff groups spoke highly of their colleagues and told us they had good working relationships with their colleagues.

**Seven-day services**

- **Key services were available five days a week to support timely patient care.**
- The service does not offer a seven-day service.
- The service was open Monday to Friday 9am to 5.30pm; staff told us this could be extended to 6pm to meet patients' need when necessary.
- Staff told us that clinical appointments were prioritised by the consultants and senior staff depending on the clinical urgency and requirement of the referrer.

**Health promotion**

- **The service had relevant information promoting healthy lifestyles and support.**
- Staff supported patients who accessed the service to live healthier lives and manage their own health, care and wellbeing. Staff gave health promotion advice with leaflets given in line with national priorities to patients and their relatives on topics relating to cardiac health such as exercise, smoking cessation and healthy eating.

**Consent and Mental Capacity Act**

- **Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 (MCA) and the Children Acts 1989 and 2004 and they knew who to contact for advice(AMSAT).**
- There were systems in place to obtain consent from patients before carrying out a procedure or providing treatment. Staff understood their responsibilities regarding consent. We saw that there was an up to date consent policy for staff.
- Staff obtained verbal and written consent from patients prior to the delivery of care and treatment. Patients told us staff gave them enough time to ask questions and they received the verbal information needed to give informed consent.
- The service had a consent form. Consent forms were signed and scanned into the system before diagnostic testing and exercise.
- At the last inspection we told the provider to ensure there was a documented procedure for the MCA and best interest principles. At this inspection we noted that MCA and best interest had been incorporated in the new consent policy.
- Staff had received training in Mental Capacity Act 2005 (MCA) and consent. Staff were able to give clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments. This was an improvement from the last inspection.

## Are diagnostic imaging services caring?

Good

Our rating of caring stayed the same.We rated it as **good.**

**Compassionate care**

- **Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.**
- Staff treated and cared for patients with compassion, respect and dignity. Feedback from patients was highly positive. We observed staff speaking to patients and families in an appropriate and caring way. Patients told us, and we observed that staff introduced themselves by their first name and job title.
- Patients' privacy and dignity was respected, during consultation and diagnostic tests. Staff used chaperones during clinic appointments. We observed chaperone notice posters were displayed in the clinic encouraging patients to ask staff if they needed a chaperone. Clinical and non-clinical staff were available to act as chaperones when needed.
- Staff followed the service policy to keep patient care and treatment confidential.
- Since the last inspection the service had re-introduced the patient satisfaction survey in May 2019 to obtain

patients feedback about the service and care received. The result showed that 72.2% of patients felt the service received by the receptionist and other staff was very good and while 27.8% felt it was good. The result also showed that 100% of patients felt they were treated with dignity and respect and would recommend the service. This was an improvement from the last inspection when we saw that the last survey forms were from 2013.

**Emotional support**

- **Staff provided patients with emotional support to minimise their distress.**
- Staff treated and involved patients and their relatives as partners in assessing and meeting their emotional needs, which was understood as being crucial in the patient's care.
- Staff understood the impact that patient's care, treatment and condition had on their wellbeing. Staff we spoke with stressed the importance of treating patients as individuals. We observed that staff talked to patients compassionately during diagnostic tests and consultations to put them at ease and minimise their distress.
- Staff provide patients with information leaflets and written information about their diagnostic tests, how to contact the centre if there were concerns and how to access their test results. Staff also signposted patients to the clinic website for further information about the diagnostic tests offered in the service.
- Patients identified in need of further emotional or psychological support could be referred to their GP for support.

**Understanding and involvement of patients and those close to them**

- **Staff made sure patients and those close to them understood their care and treatment.**
- Patients and their loved ones were treated as active partners in the planning and delivery of their care and treatment. We saw that staff were committed to working with patients, gave them appropriate information and encouraged them to make joint decisions about their care.
- We observed, and patients told us that staff were very thorough and answered all patients' questions patiently and in a considerate manner.
- We observed patients' consultations during diagnostic tests and consultations and noted that staff had clear communication with patients, discussed the tests, gave patient relevant options, and discussed the results process in detail in a way they understood. We observed good rapport between staff and patients and staff displayed good listening skills. Evidence of patients' involvement in their care was seen in their notes.
- In cases where patients were responsible for full or partial cost of care or treatment, staff provided appropriate and sensitive discussions about this.
- The May 2019 patient satisfaction survey showed that 94% of patients were very satisfied with the consultation, and 6% were satisfied. The result also showed that 88.2% felt staff explained what would happen during the tests 'very clearly' or 'fairly clearly' and 11.8% commented neither clearly nor unclearly.
- The audit also showed that 88.2% of patients felt that staff explained how the patients would receive their results and 11.8% commented they did not receive explanation from staff. The findings of the result were discussed at staff meetings and staff were reminded to discuss the test results process with patients during appointments.

## Are diagnostic imaging services responsive?

Good

Our rating of responsive stayed the same.We rated it as **good.**

**Service delivery to meet the needs of local people**

- **Managers planned and organised services to meet the changing needs of the local population.**
- Patients' individual needs and preferences were central to the planning and delivery of the service. The services were flexible and provided choice.

Good

# Diagnostic imaging

- The service provided planned diagnostic tests for patients at their convenience. We observed patients being offered different appointment times to meet their social and work-life commitment.
- The service had developed a new website in June 2019, which contained information about the clinic, cardiologist team, complaint procedures and diagnostic tests offered and the costs.
- The tests offered to patients included electrocardiogram (ECG), 24 hours blood pressure monitoring, 14-day heart monitoring, exercise test, transthoracic echocardiogram, contrast echocardiogram, exercise echocardiogram and dobutamine stress echocardiogram.
- We saw that the service made provisions to meet patient needs through access to magazines and newspapers.
- The clinic environment was appropriate and patient centred. There was a comfortable seating area, cold water fountain, and toilet facilities for patients and visitors.
- Patients were seen promptly and could book the next available appointment with their chosen cardiologist. Staff told us that patients were seen promptly following referral and there were no waiting lists.
- The service currently offered diagnostic tests for adults and had plans to offer tests to young people aged 16 to 17 years in future.

**Meeting people's individual needs**

- **The needs and preferences of patients were taken into account when delivering and coordinating services, including those who were in vulnerable circumstances or had complex needs.**
- The clinic environment was spacious and had a relaxed and homely feel. There was wheelchair access to the clinic environment using a mobile ramp and a stair lift which were suitable for people with reduced mobility.
- During the inspection we noted that the clinic was in the process of purchasing a hearing loop system to support patients with hearing aids and improve their experience.
- There was an accessible toilet on the ground floor including a call bell. There was good access to the centre by car and public transport.
- The centre had registered with a local dementia charity to improve the service provision for people with dementia. We saw that some staff had completed the dementia friends training to improve their competency on supporting patients with dementia.
- Follow up appointments were given to patients in a timely manner during clinic consultation and we saw that staff accommodated patient preferences and commitments.
- We noted that the service had not developed a procedure for treating patients with a learning disability, dementia or bariatric patients. Staff told us these patients were not routinely seen at the service. Senior managers told us they had focused on training staff on dementia and learning disability since the last inspection and they will be developing the policy in a few months.
- The service did not have a formal arrangement in place for a telephone or face to face interpretation service. Staff told us patients whose first language was not English would attend their appointment with an interpreter. Staff told us the patients that accessed the service whose first language was not English were from the embassies and they always brought their own interpreter.

**Access and flow**

- **People could access the service when they needed it during the clinic opening hours.** The service did not monitor the waiting times from referral to the diagnostic tests as most patients received an appointment within 24 to 48 hours depending on their preference and availability.
- We saw that patients could access the clinic for their diagnosis tests and consultation on the day and time to meet their needs, commitment and fit around their lives. The service planned to scan patients at the time of their choice and had a confirmation discussion with the patient about whether they wanted a morning or afternoon appointment during the week days.

Good

# Diagnostic imaging

- The May 2019 patient satisfaction survey showed that 94.4% patients found it 'very easy' to make their appointment while 5.5% found the process 'easy'.
- Referrals were prioritised by senior clinical staff according to their clinical needs, clinical urgency and requirements of the referring consultant.
- The clinic ran on time and staff informed patients when there were disruptions to the service. Staff said all patients were seen promptly and patients rarely had to wait for an appointment. During inspection there were no delays observed and patients were seen on time or before their scheduled appointment.
- The service carried out a waiting time audit on the 21 June 2019. The result showed that 33% of patients were seen before their scheduled appointment time, 33% were seen on time, 25% were seen in less than 5 minutes and while 9% seen less than 15 minutes.
- The service carried out a patient satisfaction survey on the waiting time before been seen by clinicians in May 2019. The result showed that 44% patients reported being seen on time, 50% were seen in less than 10 minutes, while 5.5% waited 10 to 20 minutes before been seen.
- From June 2018 to May 2019 there were 1,712 patient attendances recorded. The service saw an average of seven patients a day for diagnostic tests and consultations in the same period.
- The average length of stay was 60 to 90 minutes depending on the number of tests and consultations patients had.
- For the period of June 2018 to June 2019 the clinic reported there were three did not attend (DNA) appointments. The service did not have a formal DNA policy, this was included in their action plan to be developed before December 2019. Staff told us the reception staff followed up DNA appointments with a telephone call.
- Staff reported that patients' results were usually available within 24 hours for most of the diagnostic tests.
- The service carried out an audit of the turnaround time of test results for the period of January 2019 to March 2019. The result showed that 36.4% of patients received their test results the same day, 29.2% within 24 hours, 12.5% within 48 hours and 16.7% received their results within three to five working days. The result showed that the patients that had diagnostic tests such as the echocardiogram and ETT tests waited three to five working days for their result. [CM1]

**Learning from complaints and concerns**

- **There were processes in place to ensure complaints were dealt with effectively.**
- Information was provided to patients on how to report concerns and make a complaint. This was an improvement from the last inspection. However, there was no displayed poster on how to make a complaint or raise a concern.
- Patients and their loved ones could make a complaint verbally or written, by face to face contact, telephone calls or through the clinic website. Staff told us they informed patients they could give feedback and complaint via the clinic website.
- The service was in the process of subscribing with the Independent Sector Complaints Adjudication Service (ISCAS) to ensure their complaints process was more efficient.
- One of the directors was the complaints lead and was a member of the Independent Doctors Federation (IDF). Membership of the IDF allows a complaint to be referred to the ISCAS.
- The service had received an informal complaint raised with the managers about a test result. We reviewed the service response which showed that the complaint was investigated, the concern was addressed, and improvement made to the service. The patient was satisfied with the investigation process, openness and would recommend the service to friends and family.

## Are diagnostic imaging services well-led?

Good

Our rating of well-led improved. We rated it as **good.**

**Leadership**

Good

# Diagnostic imaging

- **The service had an effective leadership structure including staff with the right skills and abilities to provide high-quality sustainable care.**
- Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed. Staff told us leaders were visible and approachable. This was an improvement from the last inspection.
- At the time of the inspections the clinic was led by two managers who reported to the two clinical directors. Since the last inspection the service had recruited a new manager with clinical background. The current registered manager was due to retire on 28 June 2019 and while the new manager was in the process of registering with CQC as the new registered manager. Staff knew the management arrangements and their roles and responsibilities.
- At this inspection we noted that the leaders now had oversight on quality and how the service was managed.
- At the last inspection we had concerns that there was no joint supervision between the registered manager and the clinical directors. At this inspection we noted that the new manager had been in post for over two months and had not had a formal one-to-one meeting with any of the clinical directors. However, the new manager reported having regular informal meetings and support from the clinical directors.

**Vision and strategy**

- **The service had a vision for what it wanted to achieve and strategy to turn it into action which was developed with staff.**
- The service vision was to provide high quality, safe private care at an affordable price.
- The service had a short and long term strategy. The short term strategy was to have a foundation in place in order to support growth whilst adhering to their vision with a focus on staffing, clinic opening hours, medical equipment and a robust patient pathway. The long-term strategy focused on marketing their services to the public and to support the GPs and the patients in the local community. Senior managers told us that patients became anxious whilst waiting for referrals for diagnostic tests and the service aimed to alleviate this anxiety by offering a high-quality, safe and affordable alternative in the local area.
- The service values were underpinned by effective communication, patient safety, comfort and transparency.
- The service had a statement of purpose which outlined to patients the standards of care and support services it would provide.

**Culture**

- **Staff felt respected, supported and valued.**
- Staff we spoke with had a strong commitment to their jobs and were proud of the team working, positive impact on patient care and experience, and improvements they had made to the service since the last inspection.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Staff felt respected and that they could approach any member of staff and challenge practice or behaviour if necessary.
- Staff told us they felt supported and valued by colleagues and senior managers.
- Some of the staff we spoke with had worked for the provider for many years and enjoyed working at the service.
- The culture encouraged openness, honesty and improvement.
- Staff told us they were able to raise issues or concerns they had with their managers.
- Staff told us there was a no blame culture when incidents happened and the team supported each other at team meetings and during supervision.

**Governance**

Good

# Diagnostic imaging

- **Although there have been improvements in the governance structure and processes they were not yet sufficiently embedded to give assurance that it would provide a strengthened governance framework**
- Since the last inspection, the service had introduced various governance meetings where safety and performance were discussed and reviewed.
- The service gained assurance through various meetings such as the clinical governance meetings, health and safety meetings, senior management meetings and risk management meetings.
- The risk management committee met monthly and covered topics such as IT, building, maintenance, medicine management and key risk identified from clinical governance such as incidents.
- At the last inspection governance and risk management were not embedded in the service. There was no governance structure in place and lack of oversight on quality and effectiveness of the services, clinical policies, audits, managing of information and staff recruitment process. During this inspection, we found that the service had addressed most of the issues and now had a systematic governance process in place to continually improve the quality of service provided to patients. However, the governance meeting minutes were not comprehensive. Majority of clinical policies had been developed or updated such as the practice privilege policy.
- The clinical governance committee was held monthly and attended by senior managers and staff such as the cardiac physiologists. The meeting's agenda included appraisal, clinical audits, Medicines and Healthcare Products Regulatory Agency (MHRA) drug and medical device alerts, audits, policies, medicine management, medical devices and patient satisfaction surveys. We reviewed the governance minutes for the 29 April 2019 and 29 May 2019 and noted that the minutes were not comprehensive and did not include detailed discussions and outcome of topics discussed.
- The senior management team (SMT) held their first governance meeting on 29 May 2019. This meeting focused on topics such as finance, IT, patient satisfaction survey, and equipment. We noted that the minutes were not comprehensive and did not detail the discussion and views of staff around the topics discussed.
- The service had a lone worker risk assessment policy in place. We reviewed this document during inspection which stated it had been ratified at the clinical governance meetings on the 17 May 2019. However we noted that this was not included in the CGC governance meetings minutes on the 29 April or 29 May 2019. Although the health and safety meetings highlighted the policy had been completed but did not indicate if it had been ratified.
- Since the last inspection the manager had commenced regular staff meetings and one to one meetings with staff. Discussions and actions from the governance meetings were fed back to staff at their staff meetings, supervision and one to one meetings.
- At the last inspection we had concerns that policies and procedures were not reviewed and updated regularly. During this inspection we noted that all policies and procedures reviewed were all updated and in line with national guidance and best practice.
- The service had a recruitment policy that set out the standards it followed when recruiting staff. Managers were required to carry out appropriate background checks such as a full Disclosure and Barring Service (DBS), proof of identification, immunisation records, references check as well as driving license checks. We reviewed the staff files and found that these checks had been completed. This was an improvement from the last inspection.
- At the last inspection we had concerns that the service did not carry out local audits such as infection control and hand hygiene. During this inspection, we noted a slight improvement as some local audits had been carried out and the service now had an audit plan which detailed their audit plan.
- During inspection we noted that the clinic was in the process of registering with the Independent Sector Complaints Adjudication Service (ISCAS) to ensure their incidents and complaints procedure were more robust.

Good

# Diagnostic imaging

- The service had a liability insurance which was valid till January 2020 and displayed in clinical area.

**Managing of risks, issues and performance**

- The service had clear risk processes and systems in place for managing performance and identifying and mitigating risks. This was an improvement from the last inspection.
- Since the last inspection the service had developed a risk register and service action plan which were reviewed regularly at various governance meetings. There were16 risks on the risk register and action plan which included staff training, policies, audits, risk assessments, medical devices and clinic website. The risk register reflected we found during the inspection. One risk was classified as high risk, four were classified as moderate and 11 were minor or low risks. The risk register and risk assessments reviewed had clear lines of accountability and responsibility for actions to be taken. This was an improvement from the last inspection.
- The service had carried out a health and safety risk assessment of the service, staff and environment since the last inspection. The risk identified for staff on the risk assessment were stress and depression due to work load. These risks were mitigated with action plan for staff.
- The service had a business continuity plan that could operate in the event of an unexpected disruption to the service. This included the steps to be taken if there is potential disruption, such as fire or telecommunication system failure. The service had back-up generators which were regularly maintained and tested.

**Managing information**

- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service had an up to date confidentiality and data protection policy. This was an improvement from the last inspection.
- During inspection we observed staff treated patient identifiable information in line with the General Data Protection Regulations (GDPR). The service had a policy in place to guide staff on GDPR requirements and its implication to practice. This was an improvement from the last inspection.
- Staff had completed training on information governance and GDPR. Staff had met their compliance target on information governance.
- Information from scans could be reviewed remotely by referrers to give timely advice and interpretation of results to determine appropriate patient care.
- Patients diagnostic results were sent to the GPs or referring doctor via email using a secured system.
- The service was registered with the Information Commissioner's Office (ICO).

**Engagement**

- **Although the service had improved and now actively engaged with patients and staff to plan and manage appropriate services, improvement was needed in the engagement of the public and stakeholders.**
- Since the last inspection the clinic had re-introduced the patient surveys, one to one meetings and staff meetings to obtain their feedback about the service managers and create opportunity to raise concerns. This was an improvement from the last inspection.
- The clinical directors also held weekly staff meetings with their secretaries. This was an improvement from the last inspection.
- The bank staff reported good engagement with colleagues and leaders and received regular updates as necessary. This was an improvement from the last inspection.
- The staff held their first meetings on the 2 May 2019 and we reviewed the meeting minutes and agenda during inspection. The agenda included discussion around the terms of reference, audits schedule, new website going live, patient satisfaction survey, exercise tests to be completed only when doctors were in the building, policies and equipment.

Good

# Diagnostic imaging

- The new service manager had been invited to become an associate member of the National Association of Patient Participation (NAPP) which will help in having oversight of patients views nationally as well as sharing best practice and innovation.

**Learning, continuous improvement and innovation**

- **There was an improved culture and focus on, continuous learning, innovation and improvement in the service to improve patient outcomes.** Staff and management were committed to improving services by learning from when things went well and making changes in practice through shared learning, external reviews, promoting training and innovation.
- The service had engaged with the London Ambulance Service (LAS) to develop a hand over tool which will help improve the handover of care during clinical emergencies.
- The service had introduced various governance meetings and engaged well with the staff and patients to improve patient outcomes.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider SHOULD take to improve

- The provider should ensure that incidents are thoroughly investigated to identify learning and areas of improvement.
- The provider should take prompt action to address the concerns identified during the inspection in relation to staff understanding of duty of candour.
- The provider should ensure there are effective systems in place for managers to have oversight of staff mandatory training.
- The provider should ensure staff are compliant with the duty of candour mandatory training.
- The provider should ensure there are policies in place for staff mandatory training, did not attend (DNA) appointment, caring for patients with dementia and learning disability, turnaround time of diagnostic tests, sharps injury and caring for bariatric patients.
- The provider should ensure that the governance structure and process are robust.
- The provide should ensure there are access to an interpretation service for patients whose first language was not English.
- The provider should ensure the service actively engage with equality groups, the public and local organisations to plan and manage services.