9 Harley Street Limited

25 Harley Street

Inspection report

25 Harley Street
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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	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Inspected but not rated
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

25 Harley Street is one of two diagnostic and out-patient facilities that forms part of the Phoenix Hospital Group (PHG), Harley Street campus. The campus consists of an inpatient facility at the Weymouth Street Hospital (WSH) and a separate out-patient and diagnostic facility at 9 Harley Street.

25 Harley Street has 6 floors, arranged as follows:

The basement houses Phoenix Pathology labs, phlebotomy room, nursing station, minor procedure suite with a recovery area, staff accommodation, utility, storeroom and one office. A lift serves all floors and access ramps are available to cover the small steps at the front of the building. The service is utilised by a broad range of users including children and the elderly.

Reception and the patient waiting area is located on the ground floor. There is also a physiotherapy room, second phlebotomy room, x-ray suite, London Eye Diagnostic Clinic (LEDC), DEXA scanner, patient changing area and staff accommodation located on the ground floor. At the rear of the building there is a mews house which includes administrative offices, with their own entrance. LEDC is located at the rear of the ground floor and includes diagnostic eye testing facilities. LEDC has its own CQC registration.

The upper four floors of the building house consultation rooms and offices. All floors in the main building are served by a lift.

Number 25 Harley Street provides outpatient services supporting the following specialities: Minor surgical procedures, including dermatology, plastics and gynaecology, which are limited to local anaesthetic as no general anaesthetic is used on site. The provider also offers family planning and pathology services. Although the service is primarily adult care, they do also see children. These services are provided under the direction of specialist consultants.

The service is registered to provide the following regulated activities:

- Surgical Procedures
- Diagnostic and Screening Procedures
- Treatment of Disease, Disorder and Injury
- Family Planning

There has been a registered manager in post since the service registered with CQC in October 2018.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Outpatients	Good 	
Diagnostic imaging	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to 25 Harley Street

We inspected this outpatient service using our comprehensive inspection methodology, carrying out an unannounced site visit on 02 March 2022. During the inspection we visited reception areas, waiting areas, treatment rooms and consultation rooms. We spoke with four senior staff members, including the registered manager and reviewed a range of information provided to us. We were able to speak with three patients.

The key questions we asked during this inspection were, was it safe, effective, caring responsive and well led. We have not previously inspected or rated this service.

During this inspection, we spoke with receptionists, members of the nursing team, the registered manager, the clinical governance lead, consultants, patients and the Chief Executive Officer (CEO).

This inspection report focuses on the 'diagnostic imaging' services provided at 25 Harley Street.

How we carried out this inspection

The inspection team consisted of two inspector, one assistant inspector, and two specialist advisor.

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

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure that all staff undertake appropriate mandatory training to the required level and complete refresher training when required for their role.
- The service must ensure all equipment is checked and tested in line with manufacturers guidance and in accordance with regulations relating to ionising radiation.
- The service must ensure policies are tailored to the service, relevant and contain information using best practice guidance.

Action the service SHOULD take to improve:

- The service should ensure that a specific patient inclusion criteria is in place regarding which patients they accepted into their clinic.
- The service should review and update existing and new policies and procedures relevant to its service.
- The provider should ensure appropriate risk assessments are completed and evidenced on inspection.
- The service should use audit results are used to improve patients' outcomes and clinical care.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Requires Improvement	Inspected but not rated	Good	Good	Good	Good
Diagnostic imaging	Requires Improvement	Inspected but not rated	Not inspected	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Inspected but not rated	Good	Good	Requires Improvement	Requires Improvement

Good

Outpatients

Safe	Requires Improvement
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Good

Are Outpatients safe?

Requires Improvement

Mandatory training

The service provides mandatory training in key skills to all employed staff; however, the service could not demonstrate any medical personnel with practicing privileges had completed mandatory safety training.

Staff who were employed directly by the service (nursing, administrative and managerial staff), had achieved an 84% mandatory training compliance rate against a target of 85% overall. We requested to look at individual training compliance for selected staff members employed by the service. The registered manager was unsure which staff members worked at 25 Harley Street and which worked at other sites within the organisation.

During our inspection, we asked the registered manager to show us evidence of medical staff's compliance with mandatory training. They were unable to produce evidence of medical staff's compliance with mandatory training, nor were they able to explain how the service assures itself medical staff had undertaken the right level of training.

There was a clear mandatory training policy in place which was specific to the service; however, this policy did not state the requirements of medical staff relating to training. The service believed that medics working under practising privileges would automatically have up-to-date mandatory training as this is a requirement for them to be signed off by their relationship officer. This did not give any assurance to the service that these medics held the correct mandatory training as they did not hold any supporting evidence such as certificates within their portfolios.

The range of mandatory training available to staff was varied and tailored to the provider, which met the needs of patients and staff.

With the exception of the medical staff, there was monitoring of mandatory training and staff were alerted when they needed to update their training. This was evidenced on a spreadsheet within the online training data system. The registered manager was able to demonstrate compliance with all required mandatory training subjects.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply the learning.

Staff received training specific for their role on how to recognise and report abuse. The service had an adult and child safeguarding policy and the designated safeguarding lead was able to demonstrate their level four safeguarding training status. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

The provider was given opportunity to evidence safeguarding training relating to medical staff that worked under practising privileges, however, the service were unable to do so. It was not known if medical staff had completed this training and as a result the provider could not be confident such individuals were up to date with this subject matter.

All rooms had safeguarding reporting structure printed out and attached to the wall containing safeguarding leads name.

Cleanliness, infection control and hygiene

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

Clinical areas were visibly clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The service completed infection prevention and control, hand hygiene and sharps bin audits these ranged from 90% to 100% compliance within the last six months.

Staff followed infection control principles including the use of personal protective equipment (PPE). During inspection staff and patients wore clinical grade face coverings. Upon entering the building reception staff provided new face coverings for patients. Due to the recent government guidelines relating to Covid-19, the service had recently stopped taking daily temperature checks of patients and staff, however it was evidenced that temperature checks had been regularly documented on patients records prior to the Covid-19 legislation change. There was hand sanitiser available throughout the service, which staff and patients were encouraged to use.

Cleaning schedules were available evidencing when staff had cleaned equipment after patient use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment safely within the various areas of the building. Staff managed clinical waste well.

The design of the environment followed national guidance.

Staff carried out daily safety checks of specialist equipment. We saw evidence of a maintenance log of equipment being completed.

The service had suitable facilities to meet the needs of patients' including areas where they could sit comfortably and wait for their procedure. Lockers were available for patients to place personal items, and these were located within the patient's changing room. The service provided clear signage for fire exits and locations of fire extinguishers. Fire evacuation sledges were available for patients with disabilities to exit the building in the event of a fire. These were located in the basement and on the second floor.

The service had enough suitable equipment to help them to safely care for patients. The service had equipment required for each clinic and the consulting rooms were checked and set up each evening and morning in preparation for clinics. Equipment had portable Appliance Tested (PAT) stickers on them evidencing they had passed, and these were all within date.

Staff disposed of clinical waste safely. Waste was segregated with separate colour coded arrangements for general waste and clinical waste, sharps, such as needles were disposed of correctly line with national guidance. The provider supplied evidence of external cleaning contracts and clinical waste contract detailing frequency of collection of items such as sharps bin and clinical waste bags.

Assessing and responding to patient risk

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 was able to evidence they had a deteriorating patient policy; however, this was specific to adults not paediatric patients. The deteriorating paediatric patient policy was in draft stages during inspection and was not viewed. Staff understood how to respond to any sudden deteriorating patient and how to escalate the situation. Four members of staff were asked on the protocol and each one was able to explain how they would deal with the situation appropriately-the responses reflected the current policy. All staff had completed basic life support training in the event of patient deterioration, the registered manager reported that staff would call 999 as per policy, there were no arrangements in place with any hospital for transfer.

The service used the National Early Warning Score (NEWS). NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.

Staff completed risk assessments for each patient prior to entering the clinic. Four patient notes were reviewed by us and we saw evidence of relevant risk assessments for Covid-19. However, there was no evidence of any other risk assessments. A review of four patients records showed that clinical observations were recorded and documented during minor procedures.

Staffing

The provider ensured directly employed clinical support staff had the right qualifications skills training and experience to keep patients safe from avoidable harm

The service was able to evidence low vacancy rates for directly employed staff. There were two vacancies available for nursing staff out of a total of 10 positions, and one vacancy out of a total of four positions for receptionists. Four personnel files were chosen at random, and we saw appraisals were evidenced within each of these.

Medical staff worked on practising privileges agreements. Whilst the service was not able to evidence any mandatory training relating to medical staff, there had been employment checks, practising credentials, and background checks.

The provider had an induction process for newly employed staff. Prior to employment staff had their training credentials and background checks completed. This included a check with the Disclosure and Barring Service (DBS) prior to employment.

Good

Outpatients

The service had enough staff to keep patients safe and did not use any bank or agency staff. Management were able to adjust staffing levels based on the number of clinics due to run on the day.

Records

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

Patient notes were detailed and all staff required could access them easily using individual pass code logins to access. Records were stored securely on an internal database system. A review of four patients was chosen on the day of inspection, all were clear and complete. They included clinic letters, referral letters, clinical notes and test results, if applicable. The service mainly used digital record-keeping system, however, a low number of documents such as observation sheets and handwritten clinical notes were scanned and uploaded onto digital record system. If patients required specific referrals, these were done via letters, which the patient was also copied into evidencing clear communication.

Staff followed internal policy to keep patient records confidential.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely in accordance with their policy. Medications were securely locked in a cabinet; evidence of medication audits were seen on inspection. A nominated nurse held the key throughout shift. The service did not use any controlled medications.

Incidents

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

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's policy. The registered manager gave us an example of an alleged incident where a sharps bin had been cut open after it had been locked to continue using it. This incident was investigated and as a result improvements had been implemented including staff completing checks of consultation rooms both before and after use. The service had a digital platform that staff accessed to report incidents. All incidents were reviewed by the registered manager and senior management at a clinical governance committee (CGC). A holding letter was issued to patients providing feedback, this would be issued within two working days as per policy which was evidenced to us on inspection. Learning outcomes were then discussed in feedback session meetings and internal newsletters with staff members for future learning. The service was able to provide incident audits on inspection.

Are Outpatients effective?

Inspected but not rated

Evidence-based care and treatment

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

Good

Outpatients

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies were mostly specific to the service. One policy we reviewed was not applicable to the service as it was specific to palliative care and last offices. This was raised with the registered manager who explained that they were aware of this policy and it should have been removed previously.

The service was able to evidence use of the National Institute for health and care excellence (NICE) guidance within documentation and policies.

Nutrition and hydration

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

As procedures and consultations were short, patients were not supplied food. Water was available which patients could access independently. The registered manager informed us on inspection that hot drinks were available pre-Covid-19, however they had been removed as it was risk assessed as an infection prevention control.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

We reviewed four patient records during inspection and saw staff had recorded the administration of local anaesthetic detailing type, batch number, amount, expiry date and site of administration.

Senior staff informed us during inspection that mild pain relief was not routinely prescribed for the patient to take home, however, this was discussed post-surgery with the consultant. We were able to sit in with a patient consultation, and witnesses options being discussed. A treatment plan was printed and given to patient including prescription details.

Patient outcomes

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

The service carried out clinical audits to monitor care, treatment and implement improvements. The service was able to evidence regular scheduling of clinical audits including appropriate actions put in place to monitor and review the quality of the service.

Outcomes for patients were positive, consistent and met expectations. Managers and staff used the results to improve patients' outcomes. Regular meetings were held to ensure staff understood the information from the audits and how to improve future care, audits included sharps handling and disposal, clinical environment and infection control. Action plans were developed if an audit result fell below the target level to ensure service improvement.

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.

Employed staff were experienced, qualified and had the right skills and knowledge to meet the needs of the patients. The service was able to demonstrate appropriate recruitment checks on its staff, this included evidence of disclosure

and barring service (DBS), references, photo identification, and professional registration where required. The service was unable to evidence mandatory training regarding medical staff working under practising privileges. They could not therefore be assured that these staff members had the adequate and up-to-date training. Evidence was provided regarding regular appraisals for both employed staff and those working under practising privileges.

The service ensured that all new employed staff members had a full induction specific to their role as part of their employment. Specific qualifications relating to the job role was evidenced in staff's portfolios, for example certificates detailing Nursing and Midwifery Council (NMC) membership and General Medical Practice (GMC) memberships.

The service provided evidence of team meetings with supporting minutes, the occurrence of these meetings was in line with their own policies and were made available to relevant staff via email.

Multidisciplinary working

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

Four members of staff were interviewed, all reported working well together in the best interests of the patient. Staff spoken to, reported that team working was well established within the service and they were encouraged to discuss any issues or concerns with their colleagues. The members of staff spoken to, agreed that the service was supportive and friendly to work for.

The service evidenced a multidisciplinary team (MDT) approach when providing patient care, where necessary, the service referred onto other healthcare professionals and authorities.

Seven-day services

The service was open Monday to Friday 09:00- 20:00 and 09:00-13:00 Saturday.

Health promotion

Staff signposted patients to get practical support and advice to lead healthier lives.

The service provided health questionnaires for patients to complete as part of their consultation process. If health promotion was identified, then patients were signposted where they could receive further advice and support.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Consent from patients for their care and treatment was gained in line with legislation and guidelines. The service ensured all relevant information was given to the patient to enable them to make an informed decision regarding their care and treatment.

We viewed four patient records; all of these had completed consent forms within. Staff had good understanding regarding consent and its processes for adults and children. The service also completed consent audits.

Are Outpatients caring?

Good

Outpatients

Good

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

We observed interactions with a patient, staff understood and respected the individual needs of the patient whilst maintaining professional standards throughout the consultation. We interviewed three patients, all reported that staff treated them well and with kindness.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff encouraged patients to bring an additional person for support when visiting the clinic to minimise potential distress and assist with information processing.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Whilst on inspection we witnessed the registered manager meeting the religious needs of an individual by offering them a safe space to pray and reflect.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment to enable them to make an informed decision regarding their care. Staff were able to use a translation service for patients and families to ensure effective communication was maintained throughout their care and treatment at the clinic. The service discussed cost of treatment during consultations prior to any treatment, information was given to the patient for them to take home and make an informed decision.

Are Outpatients responsive?

Good

Service delivery to meet the needs of patients

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

Good

Outpatients

Facilities and premises were appropriate for the services being delivered. The service had a large seated waiting area for patients to use prior to staff collecting them for their consultation or treatment. Wheelchair access was available via ramps and internal lifts.

Toilets services were clean and accessible with clear signage on the doors. Medical staff maintained their own caseload and allocated enough time for each individual patient's needs, which meant not many patients in the waiting room at one time. Appointments were made to suit individuals, for example accommodating patients that needed to arrange travel.

We looked at 35 feedback forms from patients who used the service between April 2021 and September 2021, and all were positive. Comments included 'thoroughly professional service, very pleasant environment', 'good service overall, careful and attentive', 'everything went smoothly and with great professionality'.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs.

The service provided a translation service for patients that did not speak or understand English. This service was easily accessible and staff tried to ensure they were aware of communication barriers prior to patients visit.

The service could not show us they had a specific inclusion criteria regarding which patients they accepted into their clinic. The registered manager was able to verbally list the patients that did not meet the criteria to be treated at the clinic due to their specific complex needs' however, we did not see anything written down to this effect.

Portable ramps were made accessible at the front of the building where a row of small steps were, prior to entering the main reception door. Lifts provided access to all floors for those who required it.

The service offered patients a chaperone service; posters were stuck to the wall on every consultation room and in the waiting areas, informing patients of the service.

Access and flow

People could access the service when they needed it.

Patients were able to access the service when required, the registered manager reported that there were no issues with waiting times and the service was able to accommodate patient requests for appointments. Consultants held their own diaries and were responsible for booking their own patients, which meant they could be flexible and prioritise based on the patient's individual needs.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns, this was evident from talking with patients during inspection. The service provided information about how to raise a concern in patient waiting areas.

Good

Outpatients

Five complaints were reviewed, all of these had been actioned according to the services internal policies. There was evidence of holding letters sent to recipients within the timescale and none of these complaints breached their target of 20 working days as stated in policy. Management reviewed complaints and dealt with each one individually establishing trends and themes which were then discussed within patient feedback groups and meetings.

Are Outpatients well-led?

Good

Leadership

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

There was a clear management structure in place which identified lines of responsibility and accountability. The service was led by an outpatients nursing manager who was responsible for the daily running of the clinics and was the designated person who nursing staff would report to.

Staff told us that they felt they could approach immediate managers and senior managers with concerns or queries. Staff reported that they felt supported, respected and listened to within the clinic. Management held weekly meetings for staff members.

The service had an experienced, skilled, knowledgeable management team structure including, chief executive, medical director, director of operations, director of sales and marketing and chief financial officer.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services.

There was clear vision and strategy within the service specifying their vision, mission and values. The service was able to evidence clear branding positioning and communication strategy showing future growth plans of the Phoenix Hospital group as a whole and where 25 Harley Street would sit within this vision. The service had established priorities based around providing a high-quality service, these were outlined within their business strategy and future growth plans.

Strategy and vision workshops were held last year to involve staff with future planning. These workshops gave staff opportunity to give feedback regarding the future of the service

Culture

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

Staff reported that they felt able to raise concerns and were well supported from the service to do this. The service was focused on the needs of the patients, this was managed by regularly reviewing patient feedback and assessing and responding to incidents and complaints.

Yearly appraisals were conducted for staff, these discussions consisted of training and development needs for current roles along with future career development.

Good

Outpatients

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.

Staff at all levels were clear about their roles and understood what they were accountable for and who to report to. The service had a clear organisational structure in the form of a flowchart which was available on the internal system for staff to access.

Clinical governance committee meetings were held quarterly, the service was able to provide minutes of these meetings on our visit. Any reported incidents would be discussed and reviewed at these meetings and an action plan would be put in place if necessary. There was a clear process in place relating to escalation of incidents to executive level if required.

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 service had an up-to-date risk register that they were able to evidence on our visit, the register identifies specific risks and the potential impact on the service patient. Risks were regularly discussed at all governance meetings and actioned appropriately.

The service was able to evidence regular audits being conducted to monitor quality and compliance with operational processes. Some of which include, infection prevention control, sharps handling and disposal, clinical environment and consent forms. If results fell below an expected target the service would address the issue and identify learning which would be shared with the relevant teams.

There was a clear policy for unexpected events and how to address these including contact names and numbers, this was available on the internal system for staff to access.

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 service used electronic platforms where staff had individual log in details to access, if the service needed to send confidential emails documents these were sent through an encrypted software which was suitable for purpose.

Staff were able to access patients electronic records using their individual unique login details and password. Staff understood the storage of personal data is set out in the General Data Protection Regulation (GDPR).

Engagement

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

Good

Outpatients

The service provided staff meetings and feedback sessions to assist with improving treatment and care. During these meetings patient feedback was discussed with staff to identify problems, improve services and acknowledge positive feedback. The data collected was also used within the services Patient Experience Committee meeting, identifying themes and trends.

Learning, continuous improvement and innovation

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

During our inspection we saw evidence of improvement and innovation. Workshops were conducted with staff members last year to identify actions and projects to be implemented to improve the service. Workshops included the services strategy and vision moving forward which included staff feedback relating to proactive working.

The service regularly checked and updated policies in line with national guidelines and evidence-based practice.

Requires Improvement

Diagnostic imaging

Safe	Requires Improvement
Effective	Inspected but not rated
Responsive	Good
Well-led	Requires Improvement

Are Diagnostic imaging safe?

Requires Improvement

Mandatory training

The service could not demonstrate that all staff had completed mandatory safety training.

For staff employed directly by the service (nursing, administrative and managerial staff), the service achieved an 84% mandatory training compliance rate against a target of 85% overall compliance. We attempted to look at individual training compliance for staff members employed by the service, however, staff were unsure which staff members worked at 25 Harley Street and which worked at other sites within the organisation. We reviewed four staff members files and saw they had expired 'risk management' training, however, it was unclear where in the organisation these staff members were working.

We attempted to review training records for one radiography staff member during our inspection but they were unable to be located on the mandatory training system.

During our inspection, we asked to see evidence of medical staffs compliance with mandatory training. We asked the registered manager and a senior member of staff to provide us with evidence of medical staff members, chosen at random, compliance. Neither staff member were able to produce evidence of medical staffs compliance with mandatory training, nor were they able to explain how the service assures itself medical staff had undertaken the right level of training.

We asked the registered manager to demonstrate on a separate occasion, medical staffs compliance with mandatory training and they were unable to provide any evidence.

Managers told us they monitored mandatory training and alerted staff when they needed to update their training.

Post-inspection, the provider sent a list of mandatory training compliance relevant to radiology staff. This showed, on a whole, staff were mostly compliant with most mandatory training subjects. However, there were some subjects, such as General Fire Training which still required completion as they were showing as 'expired'.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff had training on how to recognise and report abuse they knew how to apply it.

Staff were aware of their responsibilities in relation to safeguarding vulnerable adults and children.

We reviewed the safeguarding policy in place and found it to be detailed. The policy covered topics dealing with adult and children safeguarding, child sexual exploitation, female genital mutilation, modern slavery and human trafficking, patients requiring advocacy services and the rights of people subject to Mental Health Act 1983.

The safeguarding lead had completed safeguarding children level four training, evidence of which was provided during inspection.

All staff (including administrative staff) had completed the safeguarding adults' level one training. All radiography staff had completed safeguarding adults' level two training.

Cleanliness, infection control and hygiene

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

Staff kept equipment and the premises visibly clean. They used control measures to prevent the spread of infection.

Most areas of the diagnostic imaging unit were visibly clean including the two diagnostic rooms, the waiting area, rest room and staff area. Patients we spoke with were satisfied with the level of cleanliness on the unit.

The service had established systems in place for infection prevention and control, which were accessible to staff. These were based on the Department of Health's code of practice on the prevention and control of infections and included guidance on hand hygiene and the use of personal protective equipment, (PPE) such as gloves.

There was easy access to PPE. Gloves were available in the diagnostic rooms and we observed staff using PPE as required. There was also sufficient access to antibacterial hand gels as well as handwashing and drying facilities. The unit displayed signage prompting people to wash their hands and gave guidance on good hand washing practice.

Staff were 'bare below the elbow' and adhered to infection control precautions throughout our inspection, such as hand washing and using hand sanitisers, and wearing PPE when treating patients.

Waste management was in line with national standards. There were housekeeping staff for cleaning the unit and staff understood cleaning frequency and standards. We observed a cleaning checklist was in use for each area of the unit and for equipment.

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.

Radiography staff had access to protective equipment to carry out x-rays and scans. There was suitable signage showing the room was a controlled area for radiation. The controlled light sign in front of the rooms was broken and we bought this to the attention of the registered manager on the day of inspection. We were given subsequent evidence post-inspection that the light had been fixed and the reason for it being broken was a blown fuse.

Requires Improvement

Diagnostic imaging

To monitor staff exposure to radiation, the radiographer was provided with a radiation dosimeter, however, it was unclear how often this was reviewed or monitored.

Post inspection, the registered manager provided evidence which showed dosimeter reports were reviewed quarterly.

We did not see evidence of risk assessments being completed for radiation exposure. This information was requested during inspection and post-inspection; however, no evidence was provided.

Subsequently, the registered manager provided a Radiation risk assessment which has been carried out by a local NHS Trust. This evidence was supplied during the draft report stage of the inspection report process.

The service had access to a physicist who was based at a local NHS Trust. The registered manager supplied evidence which showed there has been involvement by a physicist annually relating to both diagnostic modalities used at 25 Harley Street.

At the time of inspection, there was no signed agreement or contract for radiation protection services. The registered manager told us they would be seeking a meeting with a local NHS Trust who was responsible for providing radiation protection services to the provider. It was unclear, how the NHS Trust was responsible for radiation protection at 25 Harley Street, in the absence of a signed contract.

Post-inspection, the registered manager provided evidence of a signed radiation protection services contract with a local NHS Trust.

The service had maintenance and service contracts in place with manufacturers. However, it was unclear when equipment had been tested as the evidence provided was unclear and not presented in a way which was legible. The radiographer in the department was unsure when equipment had last been tested.

There was one resuscitation trolley located in the basement floor which was accessible via a public lift. There was a 'grab bag' of emergency equipment on each floor, which staff could use in an emergency. All equipment was in date and checks had been completed in line with the services resuscitation policy.

Assessing and responding to patient risk

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

Patients attended the diagnostic department for routine pre-planned non-invasive diagnostic procedures in a clinical non-acute outpatient setting and senior staff informed us they did not see unwell patients.

There was a medical emergency policy and procedure in place in the unlikely event that a patient deteriorated whilst on the premises. The policy highlighted the procedure to follow where staff are dealing with deteriorating patients. These included contacting the emergency services, providing basic life support and contacting other healthcare providers to respond to medical emergencies. However, at the time of inspection there was only a draft version of a 'paediatric deteriorating policy' which had not been ratified and reviewed at the time of inspection. We asked the registered manager to keep us updated on the development and implementation of this policy.

Requires Improvement

Diagnostic imaging

Policies relating to radiography were generic and were not tailored to the service. For example, the IR(ME)R Employer's Procedure of Exposures policy outlines, in the event that of an overexposure to radiation, the modality superintendent should ensure information is provided to the Radiation Safety department. However, the registered manager was unaware of a Radiation Safety Department in operation at 25 Harley Street or any other location managed by the provider.

Post-inspection, the registered manager supplied evidence which demonstrated risks relating to radiation were discussed as a standing agenda item in a Clinical Governance Committee (CGC) meeting. An agenda was sent to inspectors to review.

The provider's referral form included prompts to ensure the referrer had discussed pregnancy risks with the patient, and identified any special needs (such as mobility, cognition or translation services).

Staff confirmed they carried out a check of patient identity, discussed and confirmed the area to be scanned, and obtained the patients' verbal consent. They also checked patient removed jewellery and verified pregnancy status where appropriate. We reviewed pregnancy awareness letters provided to women. This highlighted the radiation risks to such women and we observed they were signed off by the relevant patients.

The service used a software programme to manage risks, incidents and complaints. All risks for the department had a named, accountable head of department. However, we did not see evidence of risks being discussed in any Radiation Governance Committee meeting minutes we reviewed.

Clinical Staffing

We were told staffing was planned around a fixed staff based intended to cover the usual fluctuations of the service. The service did not use bank or agency radiography staff.

The clinical staff were supported by nonclinical, administrative and domestic staff.

The service had an induction checklist which they used to assure themselves staff had a good knowledge and understanding of the environment and equipment they were expected to operate.

Staff told us they felt well supported by their peers, colleagues and managers.

Records

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

Patient notes were detailed and all staff could access them easily. All records were protected by password logins.

Incidents

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

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's policy.

Requires Improvement

Diagnostic imaging

The service had no never events relating to radiography in the last 12 months.

Staff received feedback from investigation of incidents from other areas of the service.

Staff met to discuss the feedback and look at improvements to patient care.

We asked for details of incidents relating to diagnostics within the last 12 months. There were no reported incidents recorded.

Are Diagnostic imaging effective?

Inspected but not rated

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Policies were not tailored to the service and did not contain information based upon best practice and national guidance. For example, the Radiation Safety Arrangements policy did not detail information relating to a medical physics expert (MPE), nor contain contact details. The policy stated staff should adhere to relevant regulations but did not outline the requirements of the regulations, nor provide information on how to access relevant guidance. The policy also gave an overview of responsibilities of a company director but did not make it clear whom the company director was with responsibilities in this area. We asked the lead for the department whom the company director was, who was referred to in the policy, however, they did not know.

The department lead told us that any new procedures must be approved by the Radiation Protection Committee (RPC), however, we did not see this in the terms of reference or as a standing agenda item when reviewing minutes and documents relating to the RPC.

We were told that service did not provide treatment to persons detained under the Mental Health Act.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment. There was limited evidence of patient outcomes being used to make improvements and achieve good outcomes.

There was limited evidence of the provider benchmarking their patient treatments and outcomes against local and national level data within the radiology sector.

There was no evidence the service participated in relevant national clinical audits.

We saw limited evidence of managers and staff using audit results to improve patients' outcomes. When the lead radiographer was asked about examples of improvements being made from any recent audit, they were unable to provide any examples.

Requires Improvement

Diagnostic imaging

It was not clear if managers shared and made sure staff understood information from the audits. When asked for evidence of this, inspectors were not provided with any. Staff were also unable to give any examples of improvements being made to the service.

Post inspection, the registered manager provided copies of meeting minutes from staff meetings which showed audits and subsequent actions were discussed amongst staff.

Competent staff

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

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

Managers gave all new staff a full induction tailored to their role before they started work. All new employees went through several checks as part of the 'on-boarding process. Specialist training for the roles was supported by the manager.

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

Multidisciplinary working

It was not clear if healthcare professionals worked together as a team to benefit patients.

We did not see any evidence of staff holding regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw evidence of meetings between different staff groups but these meetings did not discuss individual patient treatment, according to the minutes reviewed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff received and kept up to date with training on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We saw evidence of this during our inspection process.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patient's records we examined.

Are Diagnostic imaging responsive?

Good

Service delivery to meet the needs of local people

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

Requires Improvement

Diagnostic imaging

The facilities and premises were appropriate for the services being delivered.

Meeting people's individual needs

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

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

The service was accessible to patients with a disability. The radiology department was located on the ground floor to ensure people with mobility problems could access the service.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times for treatment were in line with national standards.

Staff supported patients when they were referred or transferred between services.

Inspectors were told managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Inspectors were told by staff that patients could access diagnostic testing with short notice and they had not known there to be any lengthy wait time.

The provider did not supply any information relating to the timeliness of access to the service to verify this.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Staff knew how to acknowledge complaints and we were told by the registered manager that patients would receive feedback from managers after an investigation into their complaint had been completed.

There had been no complaints received regarding diagnostics services within the 12 months prior to our inspection.

Requires Improvement

Diagnostic imaging

Are Diagnostic imaging well-led?

Requires Improvement

Leadership

Leaders had the skills and abilities to run the service. They supported staff to develop their skills and take on more senior roles.

There was a clear senior management structure within the clinic. Lines of accountability and responsibility at the clinic were clear and staff understood their roles and how to escalate problems.

We found the lead radiographer had the skills, knowledge and experience to run the department. Leaders demonstrated an understanding of the challenges to quality and sustainability for the service.

Vision and Strategy

The service had an overall vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders, however it was unclear how this related to the diagnostic services.

The provider had a vision and strategy for the future but there was little reference to the radiology and diagnostic services. Staff were unaware of a vision and strategy for the department but did feel they had been given opportunity in meetings to discuss the future of diagnostic services. Staff were unable to tell us of any plans for development of the department.

Culture

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

Managers promoted a positive culture that supported and valued staff. Staff felt respected, supported and valued and that they could approach any member of staff and challenge practice or behaviour if necessary. Staff were focused on the needs of patients receiving care.

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.

Staff we spoke with said they felt empowered to raise concerns and address any issues the service faced, openly and honestly. Staff told us they had a strong commitment to their jobs and were proud of the team working and the positive impact it had on their patients care and experience.

Governance

Leaders did not operate effective governance processes throughout the service.

Requires Improvement

Diagnostic imaging

There was no evidence of audits or quality checks for Xray or DEXA, which are the imaging modalities used at 25 Harley Street. The registered manager was given time to evidence an updated audit but was unable to. A Radiology Governance Committee December 2021 meeting minutes highlighted an audit being carried out in 2018. The lead radiographer for the department did not know when audits were last carried out or whether safety checks had been completed in accordance with clinic policy.

Post-inspection, the registered manager provided Quality Assurance (QA) checks of X-ray and DEXA used at 25 Harley Street. This demonstrated that checks are being carried out in accordance with local policy.

The service did not always follow its own recommended time frame for machine quality assurance checks to be carried out. The records we were provided with stated checks should be carried out on a monthly basis. There was no evidence checks were recorded on a monthly basis.

The terms of reference for the Radiology Governance Committee, approved September 2016 indicated that membership would constitute the Radiation Protection Advisor (RPA), amongst others. However, the Radiology Governance Committee minutes for the meeting held on 10 June 2021 and 13 December 2021 did not have input from a designated physicist or the RPA. These same minutes did not demonstrate the discussion of radiation issues or topics of relevance.

The contract for radiation protection services with an NHS trust had not been signed by either the trust or provider. It was not clear if the services had been formally arranged and agreed between the trust and the provider. Without a formally agreed contract and in the absence of knowledge of the registered manager, it was unclear the terms of the contract and whether radiation equipment had been, or was due to be, quality checked and whether compliance with the Ionising Radiations Regulations 2017 was being adhered to. The registered manager was unable to evidence a signed contract when requested.

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.

There were assurance systems at the clinic. Staff escalated performance issues through clear structures and processes. Managers met often to discuss any serious incidents, complaints, governance and safeguarding issues.

We noted staff locked their computers whenever they were away from them, this was good data protection procedure and protected the privacy of the patient from curious eyes.

We were also provided with a copy of the latest departmental risk assessment tool which listed standard ongoing risks such as staff personal safety, manual handling, clinical waste etc. The tool listed legal and company standards, existing controls, actions and whether the risk was ongoing or complete.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance.

Access to individual patient records was restricted to authorised staff who had varied access rights and editing privileges granted in accordance with their job role. Patient's records were stored in line with personal data security standards and entries made in patient's records could be easily ascertained and attributed to the person creating them.

Requires Improvement

Diagnostic imaging

The intranet was available to all staff and contained links to guidelines, policies and procedures. All staff we spoke with knew how to access the intranet and the information contained therein.

Engagement

Staff told us they felt engaged in the day to day operation of the department and could influence changes. They had regular staff meetings, which they used to share information relating to complaints or incidents for learning, sharing examples of good practice and to provide support to one another. Staff said they felt listened to when they had suggestions related to service delivery.

Learning, continuous improvement and innovation

All staff told us they were committed to continually learning and improving services.

Staff informed us they were encouraged to learn, develop and improve their skills.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must ensure that all staff undertake appropriate mandatory training to the required level and complete refresher training when required for their role. • The service must ensure all equipment is checked and tested in line with manufacturers guidance and in accordance with regulations relating to ionising radiation. • The service must ensure policies are tailored to the service, relevant and contain information using best practice guidance. • The service must ensure that all staff undertake appropriate mandatory training to the required level and complete refresher training when required for their role.