Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Inspection Report: Independent Healthcare

Service: Diverse Diagnostics, Bearsden, Glasgow

Service Provider: Diverse Diagnostics Ltd

20 May 2025

NHS SCOTLAND

Healthcare Improvement Scotland is committed to equality. We have assessed the inspection function for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Advisor on 0141 225 6999 or email his.contactpublicinvolvement@nhs.scot

First published July 2025

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1 A summary of our inspection

Background

Healthcare Improvement Scotland is the regulator of independent healthcare services in Scotland. As a part of this role, we undertake risk-based and intelligence-led inspections of independent healthcare services.

Our focus

The focus of our inspections is to ensure each service is person-centred, safe and well led. We evaluate the service against the National Health Services (Scotland) Act 1978 and regulations or orders made under the Act, its conditions of registration and Healthcare Improvement Scotland's Quality Assurance Framework. We ask questions about the provider's direction, its processes for the implementation and delivery of the service, and its results.

About our inspection

We carried out an announced inspection of Diverse Diagnostics on Tuesday 20 May 2025. We spoke with a number of staff during the inspection. We received feedback from two patients through an online survey we had asked the service to issue to its patients for us before the inspection. This was our first inspection to this service.

Based in Glasgow, Diverse Diagnostics is an independent clinic offering consultations and treatment for neurodevelopmental mental health conditions, including attention deficit hyperactivity disorder (ADHD) and autism.

The inspection team was made up of two inspectors and one clinical expert.

What we found and inspection grades awarded

For Diverse Diagnostics, the following grades have been applied.

Direction	*How clear is the service's vision and purpose and how supportive is its leadership and culture?*
Summary findings	**Grade awarded**
The service had a clear mission statement with core values to help inform the service's approach. Governance processes and reporting structures were in place to support staff delivering care. Although key performance indicators had been identified to measure the quality of the service, the outcomes of these reviews should be documented. A set agenda and more detailed minutes from staff meetings should be introduced.	✓✓ Good
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Patients were provided with comprehensive information about the services and treatments provided. Patient and staff feedback was actively sought and used to improve the service. Policies and procedures helped to support staff to deliver patient-centred care. Healthcare Improvement Scotland must be notified about certain matters that occur in the service. Processes should be in place to measure and evaluate any improvements made in the service, including as a result of patient feedback. Reporting of accidents and incidents should be in line with the service's policy. The audit programme and risk register should be further developed.	✓✓ Good
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The environment was clean, tidy and well maintained. Patient care records were clear and comprehensive. Thorough assessments were carried out to establish a formal diagnosis and inform patients' future treatment. Treatment options were discussed, including medication and self-help resources. Although staff were safely recruited., regular background and identify checks would ensure staff remain safe to work in the service.	✓✓ Good

Grades may change after this inspection due to other regulatory activity. For example, if we have to take enforcement action to improve the service or if we investigate and agree with a complaint someone makes about the service.

More information about grading can be found on our website at: Guidance for independent healthcare service providers – Healthcare Improvement Scotland

Further information about the Quality Assurance Framework can also be found on our website at: The quality assurance system and framework – Healthcare Improvement Scotland

What action we expect Diverse Diagnostics Ltd to take after our inspection

The actions that Healthcare Improvement Scotland expects the independent healthcare service to take are called requirements and recommendations.

- **Requirement:** A requirement is a statement which sets out what is required of an independent healthcare provider to comply with the National Health Services (Scotland) Act 1978, regulations or a condition of registration. Where there are breaches of the Act, regulations or conditions, a requirement must be made. Requirements are enforceable.
- **Recommendation:** A recommendation is a statement which sets out what a service should do in order to align with relevant standards and guidance.

This inspection resulted in one requirement and eight recommendations.

Direction	
Requirements	
None	
Recommendations	
a	The service should formally record outcomes when reviewing performance against each identified key performance indicator (see page 11). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Direction (continued)	
Recommendations	
b	The service should further develop the structure of staff meetings to include a set agenda, and detail the staff responsible and timescales for taking forward any actions (see page 13). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Implementation and delivery	
Requirement	
1	The provider must notify Healthcare Improvement Scotland of certain matters as noted in the notifications guidance within specified timeframes (see page 18). Timescale – immediate *Regulation 5(1)(b)* *The Healthcare Improvement Scotland (Applications and Registration) Regulations 2011*
Recommendations	
c	The service should develop clear and measurable action plans to monitor and evaluate the impact of any improvements made as a result of patient feedback, and ensure patients are informed of any changes made to the service as a result of their feedback (see page 15). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
d	The service should further develop its procedures for reporting and recording accidents and incidents to ensure this is in line with its accident and incident reporting policy (see page 18). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.14

Implementation and delivery (continued)	
Recommendations	
e	The service should ensure that information from all risk assessments is included in the risk register to ensure that all risks to patients and staff have been identified and are being managed (see page 20). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11
f	The service should address the outstanding recommendations in its health and safety risk assessment (see page 20). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
g	The service should further develop its programme of audits to cover additional key aspects of care and treatment. Audits should be documented, with improvement action plans developed, where necessary (see page 20). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Results	
Requirements	
None	
Recommendation	
h	The service should implement a system for ongoing monitoring and safety checks for staff working in the service, including those working under practicing privileges (see page 22). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

An improvement action plan has been developed by the provider and is available on the Healthcare Improvement Scotland website: [Find an independent healthcare provider or service – Healthcare Improvement Scotland]

Diverse Diagnostics Ltd, the provider, must address the requirement and make the necessary improvements as a matter of priority.

We would like to thank all staff at Diverse Diagnostics for their assistance during the inspection.

2 What we found during our inspection

Key Focus Area: Direction

Domain 1: Clear vision and purpose	Domain 2: Leadership and culture
How clear is the service's vision and purpose and how supportive is its leadership and culture?	

Our findings

The service had a clear mission statement with core values to help inform the service's approach. Governance processes and reporting structures were in place to support staff delivering care.

Although key performance indicators had been identified to measure the quality of the service, the outcomes of these reviews should be documented. A set agenda and more detailed minutes from staff meetings should be introduced.

Clear vision and purpose

The service's mission statement 'empathy and compassion are of the utmost importance… we always strive to show our genuine care and understanding… . From diagnosis to treatment… our assessments are a commitment to excellence, ensuring that our clients receive the best possible care' was stated on the service's website. A set of core values helped direct the service to deliver care and treatment. There were:

- respect
- empathy, and
- support.

The service had identified key performance indicators to help measure the effectiveness of the quality of service delivered to patients. This included collecting and evaluating data from:

- patient feedback
- complaints
- risk register
- staff turnover
- audits, and
- staff development.

We saw that the service had included a review of some of the identified key performance indicators in its quality report (2024-2025).

We were told the service had significantly expanded since it first registered with Healthcare Improvement Scotland in April 2024, and was now providing assessment and treatment for patients with neurodevelopmental mental health conditions across the UK.

What needs to improve

Although we were told performance against the service's key performance indicators was regularly reviewed, we found outcomes from these reviews were not consistently and formally recorded (recommendation a).

- No requirements.

Recommendation a

- The service should formally record outcomes when reviewing performance against each identified key performance indicator.

Leadership and culture

The medical director and clinical lead of the service was a consultant psychiatrist. They had a broad range of experience in providing treatment to patients with mental health support needs in the NHS and the independent sector. A range of clinical healthcare professionals worked under a practicing privileges contract (staff not directly employed by the provider but given permission to work in the service). This included consultant psychiatrists and registered nurses qualified to prescribe medications. The service also employed administrative staff to help support the day-to-day running of the service.

The medical director was responsible for the oversight of all clinicians contracted to work under practicing privileges. A monthly personal development plan group was held for the clinicians to share learning and discuss topics related to their professional field. Each clinician was responsible for arranging and carrying out their own clinical supervision (where staff reflect on their practice and identify any learning needs).

Systems were in place to help support safe practice and make sure the service was continually improving. This included:

- policy and procedure reviews
- patient feedback
- complaints review, and
- a 'weekly round up' newsletter to clinical staff.

A range of staff meetings took place. This included:

- daily morning brief to allocate work
- weekly staff meeting for administrative staff
- weekly senior staff leadership meeting
- weekly 'grumble' meeting, and
- monthly staff meeting.

We saw all staff meetings were minuted to record discussions that took place with actions to be taken.

The manager held regular one-to-one meetings with administrative staff, and we were told 'lunch and learn' sessions had recently started to provide informal learning for staff. Topics included guidance for staff on managing medication processes and how to resolve common issues related to patients contacting the service.

A quality assurance meeting involving the medication co-ordinator, nurse prescribers and medical director had recently been introduced. We were told this meeting was planned to take place monthly, and would provide those staff members with medication and prescribing responsibilities with an opportunity to discuss what was working well, to highlight any areas of concern or recurring themes and to share learning. Senior management told us that the introduction of the medication co-ordinator role and quality assurance meetings had had a positive impact for staff prescribing medications for the service.

Senior management acknowledged there had been a high turnover of administrative staff within the first year of the service running. From staff feedback and employee exit interviews, they had recognised that this was due to the service expanding and the resulting increased workload. As a result, changes in the staffing structure and defined roles for administrative staff had been introduced. Some members of the senior management team were receiving leadership training to help further support staff in their role. We were told this had had a positive impact on staff retention and staff morale.

What needs to improve

While we saw minutes of the various types of staff meetings, there was no set agenda for any of these meetings and the minutes did not always document which staff member was responsible for taking forward any actions identified, or the timescales for these to be completed (recommendation b).

- No requirements.

Recommendation b

- The service should further develop the structure of staff meetings to include a set agenda, and detail the staff responsible and timescales for taking forward any actions.

Key Focus Area: Implementation and delivery

Domain 3: Co-design, co-production	Domain 4: Quality improvement	Domain 5: Planning for quality
How well does the service engage with its stakeholders and manage/improve its performance?		

Our findings

Patients were provided with comprehensive information about the services and treatments provided. Patient and staff feedback was actively sought and used to improve the service. Policies and procedures helped to support staff to deliver patient-centred care.

Healthcare Improvement Scotland must be notified about certain matters that occur in the service. Processes should be in place to measure and evaluate any improvements made in the service, including as a result of patient feedback. Reporting of accidents and incidents should be in line with the service's policy. The audit programme and risk register should be further developed.

Co-design, co-production *(patients, staff and stakeholder engagement)*
The service's website provided comprehensive information on the mental health assessments and treatments available, as well as information about the clinicians' clinical background. Patients were provided with information about the assessment process, treatments and potential future costs for medication. This information allowed patients to make an informed decision about accessing treatment in the service.

We saw evidence of the service engaging with patients and the public on its social media and website. For example, information was shared on parenting support groups, self-help and articles relating to neurodevelopmental mental health.

A participation policy outlined the value and purpose of patient engagement. Various methods were used to collect patient feedback such as questionnaires, online testimonials and verbal feedback offered while in the service. The aftercare co-ordinator also telephoned patients after an assessment to obtain verbal feedback. We saw the service displayed patient feedback received on its website and social medica pages.

We saw patient feedback was reviewed every week at the leadership meeting. This information was then used to help continually improve the service delivered.

We saw examples of improvements made after receiving feedback from patients, including:

- patients' reports were now in a format that was easy for patients with a neurodevelopment diagnosis to read and understand
- consent forms included step-by-step information
- email reminders were now issued for appointments, and
- pre-appointment information about additional costs was provided.

Staff were encouraged to provide feedback about the service. This included informal suggestions, a suggestion box and an anonymous staff survey that had recently been sent out this year. For example, we were told a new coffee machine was being purchased following staff feedback.

The service recognised and rewarded staff for their achievements. We were told the service was also considering organising staff wellbeing activities including lunchtime yoga sessions and social gatherings.

What needs to improve

While we saw feedback from a recent patient satisfaction survey had been reviewed, highlighting positive and negative themes, no formal action plan had been developed or a process put in place to monitor and measure any of the improvements made. There was also no process for ensuring patients were informed of how their feedback was used to help improve the service (recommendation c).

- No requirements.

Recommendation c

- The service should develop clear and measurable action plans to monitor and evaluate the impact of any improvements made as a result of patient feedback, and ensure patients are informed of any changes made to the service as a result of their feedback.

Quality improvement

We saw that the service clearly displayed its Healthcare Improvement Scotland registration certificate and was providing care in line with its agreed conditions of registration.

A range of policies and procedures helped support the delivery of safe, person-centered care. Staff could access policies electronically or in paper format. We saw policies were reviewed and updated regularly. Key policies included:

- medication
- safeguarding (public protection)
- duty of candour, and
- infection prevention and control.

The service's medication policy referenced the National Institute for Health and Care Excellence (NICE), Scottish Intercollegiate Guidelines Network (SIGN) and the British National Formulary (BNF). The consultant psychiatrists were responsible for prescribing medication to patients following their assessments, if appropriate. We saw that patients were asked to consent for the service to obtain and share information with their GP before medication, such as controlled drugs, would be prescribed by the service. Controlled drugs are medications that require to be controlled more strictly, such as stimulant medication used to treat ADHD. This ensured the service had information about a patient's medical history before making a diagnosis and controlled drugs were prescribed. The nurse prescribers were then responsible for ongoing prescribing and medication review appointments.

An up-to-date complaints policy was published on the service's website and in the patient welcome pack. This included information on how to make a complaint and details of how to contact Healthcare Improvement Scotland, if needed. We saw that complaints and concerns were discussed at the weekly meetings, and a complaints tracker was used to record and monitor complaints received.

The service had a duty of candour policy. This is where healthcare organisations have a responsibility to be open and honest with patients if something goes wrong. A yearly duty of candour report was available on the service's website. We noted there had been one incident requiring duty of candour to be implemented. We saw staff had received training in duty of candour.

Patients were offered a free 15-minute initial telephone consultation with a clinician to allow them to discuss if an assessment would be appropriate. Consultations and treatments were appointment-only to help maintain patient privacy and dignity. We noted the majority of assessments were carried out by video link.

Assessment consultations were carried out by consultant psychiatrists who used a range of screening tools to assess the patient's medical and psychosocial history (mental, emotional, environmental and cultural factors that can influence an individual's wellbeing and behaviour) to determine if a diagnosis was appropriate. Patients were given a copy of their assessment report, and this was also sent to the patient's GP.

All patient information was stored securely on password-protected electronic devices. This helped to protect confidential information in line with the service's information management policy. The service was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights) and we saw that the service followed appropriate date protection regulations.

The service's recruitment policies were in line with safer recruitment guidance. This helped make sure that suitably qualified staff were recruited. All administrative staff had a 2-week induction and training period, including shadowing opportunities with more experienced staff.

The service's practicing privileges policy highlighted the requirements for any staff working under practicing privileges, such as making sure they were appropriately qualified and that the appropriate recruitment checks were completed. All staff working under practicing privileges worked in the NHS and kept up to date with their mandatory training in their substantive roles.

The training and development policy outlined the service's commitment to induction and supporting staff to develop their skills within their roles. It outlined responsibilities for staff and managers in relation to mandatory training. We saw that performance and development needs were discussed at regular one-to-one meetings with line managers, and we saw evidence of staff appraisals being carried out every year.

What needs to improve

Healthcare Improvement Scotland's notifications guidance details specific events and circumstances which services are required to report to us. We saw incidents recorded on the service's clinical incident reporting system that should also have been reported to Healthcare Improvement Scotland (requirement 1).

The service had a policy and procedure for reporting accidents and incidents. However, we found incident reporting and recording was isolated to clinical or patient incidents only. We discussed this with the manager, and they agreed to extend incident and accident reporting to include all incidents, in line with its own policy (recommendation d).

Requirement 1 – Timescale: immediate

- The provider must notify Healthcare Improvement Scotland of certain matters as noted in the notifications guidance within specified timeframes.

Recommendation d

- The service should further develop its procedures for reporting and recording accidents and incidents to ensure this is in line with its accident and incident reporting policy.

Planning for quality

The service had a range of policies and procedures in place to provide a safe work environment. These included:

- health and safety
- accidents and incidents
- positive environment (bullying and harassment), and
- equality, inclusion and diversity.

We saw an annual health and safety risk assessment was carried out by an external contractor.

The service had an up-to-date fire risk assessment, and we saw appropriate fire safety equipment was in place. The fixed electrical wiring and portable electrical appliances had received appropriate safety checks.

The service's risk register outlined the risk assessments for specific clinical activities which were most likely to impact patient care. For example, deterioration of a patient's mental health, and issues relating to medication and prescribing. Risks were assessed in terms of likelihood and severity, with documented actions to be taken to reduce the risks.

The service had a separate medication risk register. This highlighted particular patients who had presented with identified risks in relation to medication being prescribed by the service, and included actions taken by the service to help manage these risks. This helped to make sure the service could safely prescribe medication.

A business continuity plan described what steps would be taken to protect patient care if an unexpected event happened, such as power failure or staff absence.

We saw the service carried out a number of medication and patient information audits, including:

- demographic information on assessment reports
- diagnostic rates on the number of patients assessed
- medication prescribing rates of patients who had been treated for ADHD
- medication initiation (ensuring correct documentation had been collected in the patient care record), and
- medication review audit (ensuring relevant clinical data and patient identifiers were recorded on medication review letters).

Quality improvement is a structured approach to evaluating performance, identifying areas of improvement and taking corrective actions. We saw improvement activities to influence the service's quality report had been identified, including:

- workforce planning
- development of staff roles, and
- staff and patient feedback.

We saw examples of the service making improvements as a result of its continuous performance monitoring, including newly developed medication co-ordinator and aftercare co-ordinator roles. These helped to provide patients and clinicians with a main point of contact to facilitate transitions through the assessment, treatment and aftercare processes.

What needs to improve

Although the service had a risk register, this did not include information from all risk assessments carried out. Only clinical risks such as information breaches, medication delays or errors and incorrect diagnosis were included. Although other risk assessments had been carried out, including lone working and staffing levels, fire safety, health and safety, and business contingency, these were not included in the risk register (recommendation e).

While a health and safety risk assessment had been carried out, we saw some recommendations had not been actioned. For example, fire extinguishers in the staff kitchen had not been wall mounted and additional fire exit signs in the consultation room were still needed (recommendation f).

While the service carried out some audits, other key aspects of the service were not audited. For example, there was no evidence of infection prevention and control audits, or audits of completed private prescriptions or patient care records. We were told that the medical director reviewed ten clinical assessment reports at various points throughout the year. However, these reviews were not recorded or documented as an audit (recommendation g).

The quality improvement plan could be further developed to include areas for improvement identified through audits and policy review, as well as introducing a mechanism to measure the impact of any changes made to help demonstrate a culture of continuous improvement. We will follow this up at the next inspection.

- No requirements.

Recommendation e

- The service should ensure that information from all risk assessments is included in the risk register to ensure that all risks to patients and staff have been identified and are being managed.

Recommendation f

- The service should address the outstanding recommendations in its health and safety risk assessment.

Recommendation g

- The service should further develop its programme of audits to cover additional key aspects of care and treatment. Audits should be documented, with improvement action plans developed, where necessary.

Key Focus Area: Results

Domain 6: Relationships	Domain 7: Quality control
How well has the service demonstrated that it provides safe, person-centred care?	

Our findings

The environment was clean, tidy and well maintained. Patient care records were clear and comprehensive. Thorough assessments were carried out to establish a formal diagnosis and inform patients' future treatment. Treatment options were discussed, including medication and self-help resources.

Although staff were safely recruited, regular background and identify checks would ensure staff remain safe to work in the service.

Every year, we ask the service to submit an annual return. This gives us essential information about the service such as composition, activities, incidents and accidents, and staffing details. The service submitted an annual return, as requested. As part of the inspection process, we ask the service to submit a self-evaluation. The questions in the self-evaluation are based on our Quality Assurance Framework and ask the service to tell us what it does well, what improvements could be made and how it intends to make those improvements. The service submitted a comprehensive self-evaluation.

The clinic environment was clean, tidy and well maintained. Although the majority of patient assessments were carried out remotely, the service had one consultation room for patients to attend face-to-face consultations, if necessary. A contract was in place with an external cleaning company who cleaned the service every day.

Patients who responded to our online survey told us they were treated with dignity and respect, and were satisfied with the care and treatment they received from the service. They were confident about the skills and abilities of the clinical staff. One patient commented:

- 'The psychiatrist who assessed me for ADHD was so incredibly validating I felt so respected.'

We reviewed five patient care records and saw a good standard of record keeping. We saw thorough and comprehensive documentation in the patient care records reviewed, such as patient reports and treatment plans, and communication with the patient's GP. Patients were provided with online support resources and information about medication, including the risks and benefits.

We reviewed five staff files, including three for staff granted practicing privileges. We saw appropriate background safety checks were carried out for both employed staff and healthcare professionals appointed under practicing privileges. This included checks on professional qualifications and registration with an appropriate professional register.

What needs to improve

While background recruitment checks were carried out, the service did not repeat these checks at regular intervals to make sure staff remained safe to continue to work in the service. For example, checking the professional register, revalidation, insurance policies and criminal background checks (recommendation h).

- No requirements.

Recommendation h

- The service should implement a system for ongoing monitoring and safety checks for staff working in the service, including those working under practicing privileges.

Appendix 1 – About our inspections

Our quality assurance system and the quality assurance framework allow us to provide external assurance of the quality of healthcare provided in Scotland.

Our inspectors use this system to check independent healthcare services regularly to make sure that they are complying with necessary standards and regulations. Inspections may be announced or unannounced.

We follow a number of stages to inspect independent healthcare services.

Before inspections

Independent healthcare services submit an annual return and self-evaluation to us.

We review this information and produce a service risk assessment to determine the risk level of the service. This helps us to decide the focus and frequency of inspection.

Before

During inspections

We use inspection tools to help us assess the service.

Inspections will be a mix of physical inspection and discussions with staff, people experiencing care and, where appropriate, carers and families.

We give feedback to the service at the end of the inspection.

During

After inspections

We publish reports for services and people experiencing care, carers and families based on what we find during inspections. Independent healthcare services use our reports to make improvements and find out what other services are doing well. Our reports are available on our website at: **www.healthcareimprovementscotland.org**

We require independent healthcare services to develop and then update an improvement action plan to address the requirements and recommendations we make.

We check progress against the improvement action plan.

After

More information about our approach can be found on our website: [The quality assurance system and framework – Healthcare Improvement Scotland]

Complaints

If you would like to raise a concern or complaint about an independent healthcare service, you can complain directly to us at any time. However, we do suggest you contact the service directly in the first instance.

Our contact details are:

Healthcare Improvement Scotland
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

Email: his.ihcregulation@nhs.scot

You can read and download this document from our website.
We are happy to consider requests for other languages or formats.
Please contact our Equality and Diversity Advisor on 0141 225 6999
or email his.contactpublicinvolvement@nhs.scot

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