The Radiology Clinic

Quality Report

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

Ratings

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

Overall summary

The Radiology Clinic is operated by Central Birmingham Imaging Solutions Limited. The service does not have overnight beds but provides outpatient diagnostic services. Facilities include one x-ray room, one ultrasound room, one consultation room and office, and two changing cubicles.

The service provides diagnostic imaging, and we inspected diagnostic imaging during this inspection.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced part of the inspection on 23 November 2018, along with an announced visit to the service on 30 November 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's

Summary of findings

needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

Services we rate

We rated the service as **Good** overall.

We found good practice in relation to diagnostic imaging:

- Staff understood how to protect patients from avoidable harm and abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises visibly clean. They used effective control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- The service had enough staff with the right qualifications, skills, training and clinical experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- Staff cared for patients with compassion.
- Feedback from patients confirmed that staff treated them well and with kindness.
- The service planned and provided services in a way that met the needs of local people.
- The service took account of patients' individual needs.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

We found areas of practice that require improvement in diagnostic imaging:

- The service did not have formalised processes in place to support staff to raise safeguarding concerns.
- The service did not have effective systems to make sure staff were competent for their roles.
- Managers in the service did not always have the right skills and abilities to run a service providing high-quality sustainable care.
- Systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected were not embedded.
- The service did not have an embedded governance structure in place that was effective in systematically improving service quality and safeguarding high standards of care.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve.

Amanda Stanford

Summary of findings

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	The service has been registered with CQC since July 2017 and operates from a shared occupancy building in Edgbaston, Birmingham. The service provided imaging services, specifically x-ray and ultrasound, for adult patients aged over 18 years. The location had one x-ray room, one ultrasound room, two changing cubicles and an office, also used as a consulting room. The service treated 356 patients between November 2017 and October 2018, all of which were privately funded. The service did not currently undertake NHS work.

Summary of findings

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Background to The Radiology Clinic

The Radiology Clinic is operated by Central Birmingham Imaging Solutions Limited. The service opened in 2016. It is a private clinic in Birmingham, West Midlands. The clinic primarily serves the communities of the Edgbaston and surrounding areas. It also accepts patient referrals from outside this area.

The clinic has had a registered manager in post since 2016.

The service did not treat any children between October 2017 and October 2018.

Our inspection team

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

Information about The Radiology Clinic

The clinic has one location and is registered to provide the following regulated activities:

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

During the inspection, we visited The Radiology Clinic. We spoke with three staff including; one radiographer and two radiologists. We spoke with two patients. During our inspection, we reviewed six sets of patient records.

There were no special reviews or investigations of the clinic ongoing by the CQC at any time during the 12 months before this inspection. The service has not been previously inspected.

Activity (November 2017 to October 2018)

- There were 356 outpatient total attendances in the reporting period. Of these, 315 were x-ray appointments and 41 were ultrasound appointments. All of these patients were privately funded.

Two radiographers and two consultant radiologists worked at The Radiology Clinic.

Track record on safety

- Zero Never events
- Zero clinical incidents
- Zero Ionising Radiation (ME) Regulations (IR(ME)R) incidents
- Zero serious injuries

Zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),

Zero incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)

Zero incidences of hospital acquired Clostridium difficile (c.diff)

Zero incidences of hospital acquired E-Coli

One complaint, and this was upheld

Services provided at the clinic under service level agreement:

- Clinical and non-clinical waste removal
- Cleaning services
- Interpreting services
- Grounds maintenance
- Maintenance of medical equipment

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

- The service made sure all staff had up to date mandatory training.
- Staff understood how to protect patients from avoidable harm and abuse. Staff had training on how to recognise abuse and they knew how to apply it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- Staff completed risk assessments for each patient. They kept clear records and asked for support when necessary.
- The service had enough staff with the right clinical qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.
- The service managed patient safety incidents well. Staff recognised what constituted an incident and knew how to report them. The service had policies and procedures in place to support the investigation of, and sharing learning from, incidents.

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

- The service did not have formalised processes in place to support staff to raise safeguarding concerns.
- The service did not audit clinical compliance or quality, including medicines audits, hand hygiene and infection prevention and control audits and World Health Organisation (WHO) completion audits.

Are services effective?

We do not currently have a legal duty to rate this key question for diagnostic imaging services.

We rated effective as **Not rated** because:

Summary of this inspection

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff assessed and monitored patients regularly to see if they were in pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- Managers undertook yearly appraisals on all staff.
- Staff of different kinds worked together as a team to benefit patients. Doctors, radiographers and other healthcare professionals supported each other to provide good care.

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

- The service did not have effective systems to make sure staff were competent for their roles.

Are services caring?

Good

- Staff cared for patients with compassion and dignity.
- Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.

Are services responsive?

Good

- The service planned and provided services in a way that met the needs of local people.
- The service was working closely with other local providers of healthcare to provide a joined-up approach to diagnostic imagery.
- The service took account of patients' individual needs, meeting the requirements of the Equality Act 2010.
- People could access the service when they needed it. The service met its target to offer all patients an appointment within two weeks of referral. The service had no waiting list at the time of inspection.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Summary of this inspection

Are services well-led?

Requires improvement 

- Managers in the service did not always have the right skills and abilities to run a service providing high-quality sustainable care.
- The service did not have a formalised strategy in place to monitor progress against the vision.
- Systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected were not embedded.
- The service did not have an embedded governance structure in place that was effective in systematically improving service quality and safeguarding high standards of care.

However, we also found the following areas that the service was doing well:

- The service had a vision for what it wanted to achieve and workable plans to turn it into action.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The service was committed to improving services by learning from when things went well or wrong.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

We do not currently have a legal duty to rate the effective key question for diagnostic imaging services.

Good

Diagnostic imaging

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

Are diagnostic imaging services safe?

Good

Mandatory training

- **The service ensured all staff had up to date mandatory training.**
- The service ensured all staff had completed mandatory training required for their role.
- The service did not provide in house mandatory training for staff; however, ensured that all staff provided evidence of current and up to date mandatory training records from their substantive employer.
- Both radiologists and one radiographer provided certificates of completion of mandatory training from their fulltime employer. The remaining radiographer only undertook bank work and the provider ensured access to online mandatory training modules from a third-party provider.
- At the time of inspection, all four members of staff had completed all required mandatory training modules within the last 12 months.
- We asked three staff about their mandatory training and they all told us they had completed required training. The leadership team told us they review all staff training during yearly appraisals to ensure training is up to date.
- We found that the leadership team did not have oversight of the content of external training courses to ensure it met the needs of The Radiology Clinic and provided consistency in the training staff undertook. This posed a risk of inconsistent training being provided, and subsequently knowledge and skill level, to staff.
- We raised our concerns on site, and the leadership team told us they would look to get a breakdown of the information covered in external courses to ensure they were consistent and met the needs of the service.

Safeguarding

- **Staff understood how to protect patients from avoidable harm and abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.** However, the service lacked clear processes for escalating safeguarding concerns.
- Of the four clinical members of staff, two were trained to safeguarding level three for children, and one to level two. Three staff were trained in adult safeguarding. We saw training records to support this during the inspection. The safeguarding lead was the registered manager of The Radiology Clinic, who was children's safeguarding level 3 trained and had undertaken safeguarding adults training.
- The service reported no safeguarding concerns between October 2017 and October 2018.
- We reviewed the safeguarding adult's policy and safeguarding policy for children and young people, both implemented May 2017 and due for review May 2019. Both policies contained definitions of abuse, signs of potential abuse and up to date contact details for the local authority. Both policies contained clear guidance on the process staff should follow if they suspect abuse or harm.

- However, we found a lack of structure in the process for escalating safeguarding concerns outside of the organisation, and this was done ad hoc. The service had no formalised access to a safeguarding level 4 trained person to escalate significant concerns and receive support and guidance. A lack of structure and clear guidance posed a risk of delay in safeguarding adults and children. We raised our concerns during the inspection and the leadership team acknowledged the need for more structured governance arrangements.
- The children's safeguarding policy did not contain reference to child sexual exploitation (CSE) or female genital mutilation (FGM). Neither policy made reference to Prevent, the national anti-radicalisation programme. Providers have a duty to report all cases of suspected radicalisation, FGM and CSE to the relevant authorities. We were not assured that staff would have the information required to safeguard patients effectively.
- All three staff spoken to understood their requirements with regards safeguarding patients. We asked two staff about FGM and CSE and both could tell us what these were and how they would ensure patients were protected. The leadership team understood their responsibilities under Prevent.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well.** Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The environment was visibly clean, and staff used 'I am clean' stickers on equipment to make clear which equipment had been cleaned after each use.
- Staff demonstrated a thorough level of hand hygiene throughout the inspection. We observed staff using hand sanitiser between each patient, which reduced the risk of cross contamination and spread of infection. We observed that all staff complied with being 'bare below the elbows', not wearing watches or rings, and wearing short sleeve tops.
- However, the service did not undertake hand hygiene or environmental audits for cleanliness. This posed a risk that the leadership team did not have assurance of high standards of cleanliness and compliance with infection prevention and control measures.
- Mandatory training required staff to undertake an infection prevention and control module. All staff had completed this within the last 12 months at the time of inspection. We asked two staff about infection control, and both could explain their responsibilities in relation to preventing the spread of infection.
- Staff undertaking invasive procedures, such as joint injections, used single-use sterile equipment, including gloves, and disposed of these appropriately after use. This reduced the risk of cross infection. We found sharps containers in place throughout the service, and staff explained how and when they would use them.
- Neither radiologist undertaking joint injections had completed training in aseptic technique. This posed a risk of cross contamination if staff do not follow the principles of aseptic technique. Aseptic technique is a set of specific practices and procedures performed under carefully controlled conditions with the goal of minimising contamination by pathogens. However, both radiologists were experienced in their field of work and undertaking similar procedures and could confidently explain the principles of aseptic technique and the reasons behind it.
- We found suitable cleaning wipes in use throughout the service to clean equipment, including couches, following patient contact. Staff used disposable paper roll on the x-ray table and this was changed between each patient use. Disposable curtains were in use in the changing area and the leadership team told us these were changed regularly.
- The service had a service level agreement (SLA) in place with an external company to clean the rest of the environment, such as floors and hard surfaces.
- The service reported no incidents of healthcare acquired infections from October 2017 to October 2018.

Environment and equipment

Good

Diagnostic imaging

- **The service had suitable premises and equipment and looked after them well.**
- We found all required equipment was available, accessible and in date.
- The service had access to an emergency bag, containing resuscitation equipment, including anaphylaxis equipment. This was maintained by the owners of the premises used by the service under a service level agreement (SLA).
- We found service records in place for the x-ray and ultrasound machines. Routine maintenance was undertaken on both machines as required. We found an effective system in place to ensure timely repair of machinery when breakdowns happened. The leadership team gave two examples of when machinery had become faulty, and how this had been rectified swiftly to ensure minimal interruption in clinical care. As part of servicing, quality assurance was undertaken on the x-ray machine to ensure the correct level of radiation was delivered.
- The x-ray room was fit for purpose, and incorporated safety features required within a radiation area. The room had suitable signage outside, and a 'do not enter' sign lit up when staff were delivering radiation.
- Lead aprons and gloves were available for staff and carer use. These were routinely checked to ensure continued protection levels.
- The service did not use substances covered by the Control of Substances Hazardous to Health (COSHH) Regulations. All cleaning agents were managed by a third-party company under a SLA.
- The service monitored staff exposure to radiation within the x-ray facility. Each member of staff had an alarm system to detect high levels of radiation within the x-ray room. The management told us this was monitored on an ongoing basis.

Assessing and responding to patient risk

- **Staff completed risk assessments for each patient.** They kept clear records and asked for support when necessary.
- The service planned for emergencies and staff understood their roles if one should occur.
- The medical emergency policy, although had no implementation date, review timeframe or date or version control, was in line with current Resuscitation Council guidelines on basic life support.
- All staff had completed basic life support training for children and adults in the last 12 months. Staff had access to resuscitation equipment and two staff asked knew how to access this.
- Risk assessments were undertaken on patients and appropriate questions were asked of patients before undergoing imaging or interventional procedures.
- All women of child bearing age were asked if they could be pregnant before undergoing an x-ray. We saw signage in each clinical area advising any female patient who was or could be pregnant to discuss this with a member of staff before the procedure.
- The service monitored diagnostic reference levels (DRL). The radiation protection advisor (RPA) monitored these on a regular basis, and the service had oversight of the DRLs within the service.
- All patients undergoing joint injections under ultrasound were asked about allergies and if they were diabetic, as there is an increased risk to patients with diabetes if undergoing a joint inspection.
- The service used the World Health Organisation Safe Surgery Checklist prior to any interventional procedure. This increased the safety of patients undergoing procedures. Checklist

Medical and non-medical staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- The location employed two radiographers, one 0.2 whole time equivalent (WTE) to cover clinics and the second on a bank basis to cover for sickness and annual leave.
- The service had access to 0.1 WTE hours of administration time.

- The service employed two consultant radiologists, both were the directors. This provided enough cover to ensure a consultant radiologist was available on site or via telephone during each clinic and images were reported on in a timely fashion.
- The service planned staffing to meet the demands of the service. The leadership team reviewed staffing on an ongoing basis to ensure it continued to meet requirements.

Records

- **Staff kept detailed records of patients' care and treatment.** Records were clear, up-to-date and easily available to all staff providing care.
- The Radiology Clinic held electronic and paper medical records for patients attending the clinic for imaging. The records consisted of a registration form for new patients, a referral form or letter from a consultant and a copy of the report from the radiologist with findings and suggested diagnosis.
- We reviewed six patient records during the inspection. We found all to be completed in full. All records reviewed had a completed referral form or referral letter from a consultant and a fully completed imaging report.
- All records contained the patient's name, address and date of birth. All records looked at contained the image required, including the correct side (left or right) if appropriate.
- We found records were stored securely within a locked filing cabinet in a locked office. The key to both was kept securely and was only accessible to members of staff that should have access to it.
- Electronic records, such as the x-ray images, were stored securely on a computer system. The system was encrypted to ensure only authorised persons could access this. A back up system was in place to ensure that data and records were not lost in the event of power failure.
- However, we did find the computer left logged on and patient details and x-ray images left accessible. Staff did acknowledge that this was of concern, and mitigated the risk by ensuring the door was kept shut when staff were not in the room.

Medicines

- **The service followed best practice when prescribing, giving, recording and storing medicines.** Patients received the right medication at the right dose at the right time.
- The location did not order, store and use controlled drugs as part of its work.
- The location did not have any non-medical prescribers within the organisation and did not use any patient group directives (PGDs) within its work.
- Staff could access pharmacy support through a service level agreement (SLA) with a local pharmacy service.
- We found the service ordered, stored and administered medication is a safe way. However, we found staff did not undertake medicine management training as part of mandatory training. We found the service did not undertake medicine audits.

Incidents

- **The service managed patient safety incidents well.** Staff recognised what constituted an incident and knew how to report them. The service had policies and procedures in place to support the investigation of, and sharing learning from, incidents.
- The provider reported no serious incidents from October 2017 to October 2018.
- The provider reported no incidents relating to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) from October 2017 to October 2018.
- The service reported no incidents meeting the requirements of duty of candour from October 2017 to October 2018. Providers of healthcare services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.
- We asked two members of staff about duty of candour. Both could explain what duty of candour was and their responsibilities in relation to the regulation.

Good

Diagnostic imaging

- We found an incident reporting policy in place. We asked two members of staff about reporting incidents. Both staff could explain what they would do in the event of an incident occurring.
- We noted that there was no availability of external review of incidents, particularly clinical incidents. However, the leadership team were aware of this and had recently implemented a medical advisory committee with the other providers working in the same location to oversee all medical care and investigate where things go wrong.

Are diagnostic imaging services effective?

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness.** Managers checked to make sure staff followed guidance.
- We found policies within the organisation referenced current best practice. For example, the medical emergency policy was in line with the current guidance from the Resuscitation Council.
- The service used the World Health Organisations (WHO) safe surgery check-list prior to undertaking invasive procedure, such as joint injections. The WHO check-list is a step by step process to ensure the correct patient receives the right treatment in the right part of the body.
- We found the service complied with the requirements of the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)2017. However, we found the services IR(ME)R policy did not fully reflect the requirements of appendix two of IR(ME)R. The policy did not contain areas that covered each of the 15 points of appendix two. However, the leadership team was aware of the requirements of IR(ME)R 2017. The leadership team told us they would review the policy to ensure it was compliant with the requirements of IR(ME)R.
- We found radiologists reviewing and reporting on images would refer patients with abnormal results to a specialist for further follow up. The management team gave an example of when an abnormality was seen on an x-ray and the patient was referred to a specialist, reviewed and a diagnosis given within three days of The Radiology Clinic reporting the x-ray.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain.**
- Staff undertaking interventional procedures, such as joint injections, did advise patients accordingly with regards discomfort and pain control.

Patient outcomes

- **Managers monitored the effectiveness of care and treatment and used the findings to improve them.** They compared local results with those of other services to learn from them.
- The service double checked 10% of x-ray image Reports meaning a consultant radiologist reviewed 10% of the other radiologists' work. The audits included the radiographic quality of the x-ray, language used within the report, quality of clinical opinion and appropriateness of advice given to patients.
- From January to June 2018, the service undertook 167 x-rays, and audited 10% of these (16). The audit found a minor technical issue on one image and the action plan showed the leadership team reported the fault to the servicing company for repair.
- The service audited reporting times to ensure an effective, timely reporting process. Between June and August 2018, we found that the service reported on images in an average time of 4.7 days. However, the service did not compare this result to any other organisation or benchmark this nationally to assure themselves this is an effective and robust timeframe for reporting.

Competent staff

- **The service did not have effective systems to make sure staff were competent for their roles.** However, managers appraised staff's work performance.

Good

Diagnostic imaging

- The service provided a yearly appraisal for all staff. At the time of inspection, we found all staff that required an appraisal had received one in the last year. Copies of the appraisals were kept in staff files.
- New staff joining the service underwent competency assessments for the use of the machinery within the x-ray room. These competencies were overseen by a currently competent member of staff at the service.
- We found the leadership team did not have a good oversight of the ongoing competence of radiographers within the service. The leadership team monitored competence through the quality of the images being produced. This was not an effective way of monitoring competence in the use of imaging equipment.
- The service provided continued professional development for staff. One radiographer was undertaking the lead role for ensuring the continued safety medical equipment. The radiographer had recognised a more effective way of working, and the leadership team supported them to undertaken additional roles within their day-to-day work.

Multidisciplinary working

- **Staff worked together as a team to benefit patients.** Doctors and other healthcare professionals supported each other to provide good care.
- We found a good working relationship between The Radiology Clinic staff and other providers within the location. We observed interactions between radiographers and consultants referring patients for imaging.
- We found a culture of inclusive working between the radiographers and radiologists within the service. Staff asked felt supported by the leadership team and included in decisions about progression and patient care.
- The leadership provided an example of a patient who underwent an imaging procedure and the results were unexpected. The radiologist contact specialist staff within an NHS organisation locally for advice and the patient was urgently referred and seen by specialists within 24 hours.

Seven-day services

- The service did not operate seven-days a week. The service was available every Friday for booked x-ray clinics. Radiologists would book further clinics to accommodate patients requiring urgent x-ray or urgent and routine ultrasound images.
- The radiologists would work each Friday to ensure that images were reported on as soon as possible.
- Patients could contact the service seven-days a week by phone or email. Radiologists were available for specialist advice for referring consultants.

Consent and Mental Capacity Act

- We asked two members of staff about the Mental Capacity Act 2005. Both staff could describe their responsibilities in relation to assessing mental capacity of patients undergoing imaging or interventional procedures.
- The leadership team had recognised the service had limited resources to support patients that lacked the capacity to consent to treatment to maintain their safety and wellbeing and this would be reviewed on a patient by patient basis. The service did not accept patients that were unable to consent to treatment themselves due to a lack of capacity.
- We asked two members of staff about consent. Both members of staff could describe their responsibilities in relation to gaining consent prior to undertaking any intervention. We observed staff taking verbal consent prior to undertaking an x-ray. The service took written consent prior to interventional procedures, such as join injections.
- The service audited compliance with consent form completion for joint injections in August 2018. The audit reviewed 10 records of patients that had undergone ultrasound guided injections and found in all 10 cases a consent form had been completed and signed.

Are diagnostic imaging services caring?

Good

Compassionate care

Good

Diagnostic imaging

- **Staff cared for patients with compassion.** Feedback from patients confirmed that staff treated them well and with kindness.
- We observed the care of two patients during the inspection, spoke with staff about patient care and reviewed feedback gathered by the service from patients.
- We observed staff treat patients with kindness and compassion. Staff treated all patients observed with respect and spoke to them in a calm and reassuring manner.
- Staff ensured patients dignity was maintained at all times. When patients required to change into a gown, staff ensured that patients remained covered as much as possible when walking between the imaging room and changing area.
- We observed staff informing patients before they left the x-ray room if their gown was not fastened properly and assisting in this to maintain dignity. We observed a member of staff covering a patient with a sheet during a procedure to promote their dignity and privacy.
- Staff asked both patients if they were ready before entering the changing area to maintain the privacy and dignity of the patients.
- Staff offered chaperoning to all patients undergoing interventional procedures. All patients had the opportunity to request a chaperone for any imaging procedure. The Radiology Clinic displayed signage throughout the clinic informing patients they could request a chaperone.
- We reviewed feedback forms from January to August 2018. The service received 31 feedback forms. Of the 31 responses, 30 patients stated they were “likely” or “extremely likely” to recommend The Radiology Clinic to friends and family. The remaining respondent stated they were “neither likely or not” to recommend the service.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- For booked appointments, staff allowed up to half an hour to undertake an x-ray to promote time for patients to ask questions and for expert staff to provide guidance and reassurance where needed.
- Patients attending for a radiologist led ultrasound scan had time within the appointment to ask questions and discuss the results and diagnosis before leaving the clinic. The appointments were made for an hour, which allowed for the time to discuss concerns and worries.
- During imaging, we observed staff provide support to patients, discussing unrelated topics to the imaging procedure to provide a calm, distracting environment for the patient.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- We observed staff involve patients as much as possible in the process of undertaking a diagnostic image.
- Staff asked in the two interactions we observed if the patient knew the reason for the image and what part of the body was being imaged. Time was given to patients to ask questions about the procedure, and staff answered all question calmly and confidently.
- We found that staff were open and transparent about the charges for self-paying patients. We observed reception staff have sensitive discussions when taking payments.

Are diagnostic imaging services responsive?

Good

Service delivery to meet the needs of local people

- **The service planned and provided services in a way that met the needs of local people.**
- The service was planned with a ‘one stop clinic’ methodology, promoting a more convenient and

timely experience for the patient. The service aimed to provide investigations and clinic appointments in the same visit to reduce the need for multiple appointments for the patient.

- All patients were given a copy of the images taken on a CD to take home.
- Staff organised booked appointments at the start and end of each day, so as to reduce the impact and delays during clinic hours on 'same day' referrals.
- The leadership team had recognised that patients wanted time at appointments to discuss any concerns or worries they had. Appointments for ultrasound scans were one hour long, allowing patients to undergo the procedure and get a diagnosis and report in one day. The length of the appointment allowed time for the patient to discuss the results and any concerns with the radiologist straight away.
- The leadership team understood the limitations of what the service could provide and how to keep patients safe during procedures. The leadership team had in place criteria for patients they would accept and treat. The clinic would not undertake interventional procedures on any patient under the age of 18 years. The clinic would not undertake any diagnostic imaging on patients who could not consent for themselves, such as patients living with dementia. This was due to the limited number of staff to support these patients during the procedure.
- The leadership team worked closely with other local healthcare providers to ensure services provided by The Radiology Clinic were in line with the needs of the local community, and to forge new working relationships with local providers to give more timely access to imaging services for a wider group of patients.
- Service level agreements were in place to support the current work undertaken. The service was in consultation with another local supplier to establish shared working to provide a wider range of imaging services, including magnetic resonance imaging (MRI) scanning.
- The leadership team displayed a good knowledge of the requirements under the Equality Act 2010. They explained the complex and growing diversity of Birmingham city and the need to continue to work to meet the needs of that community.

Meeting people's individual needs

- **The service took account of patients' individual needs.**
- The service was not wheelchair accessible when the current leadership team started. The leadership team made alterations to ensure all areas of the service were now accessible for patients with limited mobility or those who used a wheelchair.
- Staff could access a translation service. The leadership team told us that staff would book face-to-face translation services where the need was known prior to the clinic. Telephone translation was available where this was not known.
- The service had information leaflets available in different languages and could access a document translation service to translate medical reports into a language the patient could read.
- The service promoted the use of chaperones throughout the clinic. All patients undergoing interventional treatments were offered a chaperone before commencing the procedure. Any patient could ask for a chaperone at any time. We saw posters displaying information on who to request a chaperone.

Access and flow

- **People could access the service when they needed it.** Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- The service saw 356 patients between November 2017 and October 2018. Of these, 315 were x-ray appointments and 41 were ultrasound appointments.
- Referring clinicians contacted the clinic to arrange appointments. Patients were booked into the next scheduled clinic. Consultant radiologists assessed

urgent referrals. If they could not accommodate these, the radiologist referred the patient to another provider. This ensured the patient was seen in atimely manner.

- The service had no waiting list for either x-ray or ultrasound at the time of inspection. The service had additional unfilled capacity at the time of inspection, which was part of the vision for expansion of the service.
- The service had a target of seeing all patients referred to the service within two weeks. The service audited 50 patients for referral to treatment times between August 2017 and September 2018, and found 98% of patients were seen within two weeks of referral. The one patient (2%) that had not been seen was due to personal circumstances of the patient; however, the provider had offered them an appointment within two weeks of the referral.
- The service had four patients awaiting an appointment at the time of the inspection; however, these were all for reasons outside of the clinics control, such as patient preference.
- The service cancelled two clinics, with a total of 12 patients affected, from October 2017 to October 2018. Both clinics were cancelled due to equipment failure. The cancelled patients were reviewed and followed up at the next available clinic.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**
- The service recorded one complaint between October 2017 and October 2018.
- We reviewed the investigation and response to the one complaint made from October 2017 to October 2018. We found the service responded in a timely manner to the initial complaint. The final response to the complaint addressed the concerns raised, apologised and detailed improvement plans and changes that would be made to ensure the service can improve.
- During the inspection, we found the recommended changes had been implemented and no further instances of complaints had been received.
- The service recorded no instances of informal complaints or compliments being received.
- We saw posters in each clinical area informing patients how to make a complaint. No patients during the inspection asked to make a complaint; therefore, we were unable to assess the immediate response of the service to complaints.

Are diagnostic imaging services well-led?

Requires improvement

Leadership

- **Managers in the service did not always have the right skills and abilities to run a service providing high-quality sustainable care.**
- The Radiology Clinic was a small service, with four employees. The registered manager and nominated individual made up the leadership team.
- The service had some guidelines in place for how the board would operate and function. The leadership team formally met once a year to review the service, and these meetings were minuted. The leadership team met ad hoc throughout the rest of the year; however, these discussions were not documented.
- We found the leadership team, although committed and passionate about the service, lacked some of the skills and knowledge required to effectively lead the service. However, the leadership team had recognised their own gaps in skills and knowledge and had sought external consultancy to improve their skills and knowledge around managing and providing regulated activities.
- The leadership team did demonstrate an understanding of the challenges facing the organisation, both in the short term and in the longer term. Some of these included: equipment breakages, the ability to expand the service and increase patient

numbers, the ability to employ and retain enough staff to effectively maintain and expand services, and the delivery of a high standard of care to patients when working in partnership with other organisations.

- However, we found that although the leadership team could articulate the challenges faced, there was no formalised recording or monitoring of these.
- Staff told us that the leadership team were approachable and supportive in all aspects of their work. We found the leadership team were supportive and encouraging of staff, and were available for concerns and queries at all times when the clinic was open.

Vision and strategy

- **The service had a vision for what it wanted to achieve and workable plans to turn it into action.** However, the strategy to achieve the vision had not been formalised and had no monitoring of progress.
- The service had a clear vision for improvement and sustainability moving forward; however, this was not formalised and written down.
- The leadership team explained the vision and strategy had three parts to it: improving and developing the relationship with the other providers in the location they were based, improving and forging relationships with external providers around Birmingham and thirdly to work closely with other providers within the local community (known as the Edgbaston Medical Quarter) to develop community wide services.
- We asked three staff members about the vision for the service, and all could describe and explain the vision and strategy for the future. However, we found the leadership team had not formalised the strategy to ensure robust monitoring and oversight of progress against key targets.
- The service had a business plan in place at the time of the inspection. The leadership team routinely reviewed the business plan, and this was done in February and October 2018.

Culture

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- We found a culture that was patient centred and provided support to staff throughout their roles. We asked three staff about the culture within the organisation and all three told us they felt supported and part of the wider team.
- We found a culture that encouraged openness and transparency. We found the culture encouraged learning and development of the service. We found examples of staff self-identifying gaps in the service and implementing changes. We also found an example of a complaint that was responded to in a timely manner and appropriate changes made to prevent similar problems happening again.
- We found a strong emphasis on the safety and welfare of staff. Managers had implemented required safety procedures to protect staff from radiation exposure. Staff never worked alone in the building, promoting the safety of staff.
- Three staff told us that the working relationships between all levels of staff, both employed directly by The Radiology Clinic and under service level agreement, were productive and supportive. We observed during the inspection collaborative working between administrative staff and radiographers. We observed supportive relations between the management and other staff within the service.

Governance

- **The service did not have an embedded governance structure in place that was effective in systematically improving service quality.**
- We reviewed five policies as part of the inspection process:
  - Complaints policy
  - Incident reporting policy
  - Patient record keeping policy
  - Safeguarding policy
  - Medical emergency policy

- We found inconsistencies in the policies at The Radiology Clinic. Not all policies had implementation and review dates, and we were not assured that all policies were updated in a timely fashion. For example, the medical emergency and resuscitation policy, and the incident reporting policy had no implementation date, review date or version control. However, the patient record keeping policy, and the adult safeguarding policy, both had implementation dates, reviewer timeframes and version control within them.
- We raised our concerns with the leadership team during the inspection who told us they were aware of this and policies were being reviewed to ensure consistency across the organisation.
- Following the inspection, the leadership team told us that they were formulating a more robust governance plan, and would implement this over the next six months. This gave us assurance that the leadership had reacted appropriately and in a timely manner to the concerns raised during the inspection.
- We found the governance system in place was not robust. The leadership team formally met once a year to review the service, risk register, strategy and business plan. The leadership team met in between this; however, these discussions and actions were not documented. Therefore, we did not have assurance of organisational development and timely changes.
- We found no formalised clinical governance systems in place to have oversight of clinical effectiveness and delivery. However, following the inspection, the leadership team told us they plan to implement a clinical governance system to have oversight of:
  - Clinical effectiveness and research
  - Risk management
  - Education and training
  - Patient and public involvement
  - Using information and IT
  - Staffing and staff management
- The leadership team provided assurance that, following the inspection, further improvements would be made to the governance arrangements to ensure they were fit for purpose. The leadership team provided us with actions that would be undertaken, including: reviewing all policies to ensure were fit for purpose and reviewing the formalisation of the collection and review of data to improve the quality of care.
- The service did not hold staff meetings and information was shared ad hoc with staff. However, due to the small numbers of staff, there was a minimal risk of the leadership team not sharing information. Staff told us they felt the leadership team did update them of changes within the organisation.

Managing risks, issues and performance

- **The service did not have embedded systems to identify risks, and plan to eliminate or reduce them.**
- We reviewed the risk registers for the service and found they were not fit for purpose. The service had five risk registers named: Radiology Clinic, equipment, 81 Harborne Road, company and staff. Across the five risk registers we found 54 entries.
- The risk registers were limited in detail, for example they did not state when the risk was added or when it was last reviewed or next needed reviewing. Not all risks had an allocated lead person to oversee it. We found 11 risks that had been marked as “done” and another seven risks with initials in the ‘done’ column. The equipment risk register listed all the equipment used at the service, for example paper towels, patient gowns, sterile packs and hand wash; however, provided no further detail on the reason these were on the risk register.
- During the inspection, we found risks that had not been added to the risk register, such as uneven flooring, the risks associated with delivering radiation, technology infrastructure or the impact of short notice staff sickness or equipment failure. We were not assured that the risk register was a working document and that it was a true reflection of current risks.
- We raised our concerns about the risk register with the leadership team during the inspection, who acknowledged that it was not in line with best practice and did not reflect the risks associated with the service.

Good

Diagnostic imaging

- Following the inspection, the leadership team took timely actions in respect to the risk register. The leadership team reassessed all risks at the service and provided an updated risk register that identified the risk, what control measures had been put in place and who was responsible for the risk. The revised risk registers also detailed any further actions needed and a review date.
- The leadership team introduced, following the inspection, a new risk assessment to assess all new risks identified in the future. The risk assessment form was detailed and identified the areas needed to effectively review new and emerging risks.
- We found the leadership team did not have sufficient oversight of the service to manage risk and performance. The service did not undertake audits for infection prevention and control, medicines or World Health Organisation (WHO) checklist completion. This posed a risk that the leadership team would be unable to identify and improve the quality of care provided.
- The leadership team did provide two examples where they had identified risks and made changes to reduce the seriousness and impact of these. The building did not have any resuscitation equipment prior to The Radiology Clinic starting. The leadership team recognised this was a risk as they were performing invasive procedures; therefore, worked with the other providers at the location and implemented a shared resuscitation bag and anaphylaxis kit.
- The leadership team recognised the importance of oversight of medical clinician's work when working with multiple providers. The leadership team raised concerns with the other providers utilising the building about bringing in additional staff on practicing privileges who could refer into The Radiology Clinic. Practicing privileges are when a medical professional is awarded a contract to practice, usually at an independent health service. As a result, The Radiology Clinic had initiated, with the other providers operating from the same location, a medical advisory committee (MAC) to oversee the performance of medical staff with practicing privileges.

Managing information

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.** However, the information collected was limited.
- The service collected and analysed some information to support in the continued provision of high quality care, and future expansion of services. However, we found this information to be limited.
- The service audited referral to treatment times and the quality and timeliness of images taken. We found some limited improvement plans in place following this.
- However, reviews of other local services in line with the vision to expand the service had not been formally recorded. We did not have assurance of a structured approach to using information from external partners in the development of the service.
- The leadership team demonstrated a good knowledge and understanding of the General Data Protection Regulations (GDPR) and the challenges faced in relation to this. The leadership team were reviewing the possibility of remote access to images for specific staff to allow for more timely reporting of images; however, acknowledged the need for suitable security measures to be in place.
- We found privately funded patients were given information about the cost of the imagery before commencing the procedure. We found patient received a detailed statement of cost following the procedure.

Engagement

- **The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.**
- The service asked all patients for feedback following an appointment. The service acknowledged a low uptake of feedback forms and were actively looking at alternative ways to engage with the public.

Good

Diagnostic imaging

- The service had recently upgraded The Radiology Clinic website to make this more accessible and easier to use for patients. The leadership team told us this was under constant review to ensure it meets the needs of patients.
- The leadership team have actively sought to engage with other providers of healthcare in the local area, known as the Edgbaston Medical Quarter. The Radiology Clinic had recently started attending meetings across the Edgbaston Medical Quarter to work collaboratively with other providers.
- The leadership team were in discussions with other providers to undertake joint working to deliver a wider range of diagnostic imagery, including magnetic resonance imaging (MRI) scans under a service level agreement.

Learning, continuous improvement and innovation

- **The service was committed to improving services by learning from when things went well or wrong.**
- We found a culture within the leadership team that promoted learning and improvement. The leadership team were engaged throughout the inspection process and demonstrated passion and enthusiasm to want to improve and better the service.
- Following the inspection, the leadership team reviewed and changed processes around risk management, including implementing a new risk register and risk assessment tool. The timeliness of the changes and implementation of new ways of working provided assurance of a want to improve and sustain the service.

Outstanding practice and areas for improvement

Outstanding practice

- We found the service provided a very responsive service to patients, including: in the accessibility of appointments, the referral of patient to other providers rather than simply refusing to treat, but also in the provision for those patients with specific needs under the Equality Act 2010.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure it has effective, structured governance systems to systematically improve service quality and safeguard high standards of care.
- The provider must ensure effective policies and procedures are in place to support staff to raise safeguarding concerns in a timely manner.

Action the provider SHOULD take to improve

- The provider should ensure that all staff receive a consistent level of mandatory training, regardless of the provider of the training.
- The provider should ensure it has an effective system for monitoring ongoing competence of staff.
- The provider should ensure that the oversight and management of risk is sustainable and fit for purpose.
- The provider should ensure a robust system to audit clinical effectiveness.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have a risk register in place that was fit for purpose or reflective of the operationally or organisational risks. The provider did not monitor or update the risk register to ensure it reflected the risks associated with the provision of the service. The provider did not have an embedded governance structure in place to ensure robust oversight of the care delivered to ensure it was of good quality. The provider did not have a system in place to review and update policies and procedures on a routine basis, or ensure the policies and procedures in place were applicable to the services being delivered. Regulation 17(2)(a)