Image Diagnostic Technology Limited

Image Diagnostic Technology Ltd

Inspection report

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

Ratings

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

Summary of findings

Overall summary

We rated the provider as inadequate because:

- Staff employed at the service did not receive or complete a list of mandatory training that was applicable for their job role.
- The service did not have safeguarding policies or processes in place.
- The provider did not have assurance of the quality of the display screens that radiologists were using for reporting.
- Incidents were not clearly reported in a suitable format to enable learning or improvement.
- The provider did not ensure work was in line with evidence-based practice.
- The manager did not have effective audits in place to measure the effectiveness of the service that they provided.
- The service did not have a written vision and strategy for what it wanted to achieve and workable plans to turn it into action.
- The provider did not have standardised methods for reporting, and there were no policies or protocols in place.

However:

- Clear patient records were kept in line with General Data Protection Regulation (GDPR).
- The service had access to another tele radiology provider to assist with a backlog of reports.
- Staff we spoke with spoke highly of the manager.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Inadequate 	We rated it as inadequate because: • Not all staff had up to date training in key skills. There was a lack of safeguarding oversight. The provider did not always have data security assurances at all times. The service did not manage safety incidents well nor did they learn lessons from them. • Managers did not monitor the effectiveness of the service through thorough auditing processes or ensure assurance of staff competencies. • The service took account of client's individual needs but there was no formal process to provide feedback. • Leaders did not run services well, there was a lack of reliable information systems that ensured the manager that staff had appropriate skill sets. There was no vision statement or values in place which staff could apply in their work. However: • The service had access to enough radiologists to review images for referrers. The provider kept detailed patient records. • The service had an appropriate contingency plan in place.

Summary of findings

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Summary of this inspection

Background to Image Diagnostic Technology Ltd

Image Diagnostic Technology also known as IDT scans is a limited company founded in 1991. The provider's main work is to provide diagnostic dental reports for dental imaging centres, for patients requiring dental treatment or diagnosis using teleradiology. Teleradiology is the transmission of patients' radiological images between different locations to produce an imaging report, expert second opinion or clinical review. The provider works with a network of dental imaging centres providing a service for the whole of the UK and Ireland.

The service is registered to provide the following regulated activities:

- Diagnostic and screening procedures.

The provider has a manager registered with CQC. The provider employees two staff members, the registered manager and the company's secretary. IDT scans subcontracts three radiologists to review and provide the dental imaging reports.

This was the first comprehensive inspection since the provider was registered in January 2020.

How we carried out this inspection

During the inspection visit, the inspection team:

- Visited the main office of IDT scans.
- Spoke with the registered manager and the company secretary.
- Reviewed client records.
- Reviewed 2 records of patients.
- Looked at other documents relating to the running of the service.

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

Due to the concerns found at this inspection we issued a requirement notice under Section 29 of the Health and Social Care Act 2008.

In addition to the requirement notice, 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. Details are at the end of the report.

Areas for improvement

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

Action the service MUST take to improve:

Summary of this inspection

- The service must ensure that staff employed completed appropriate mandatory training on a regular basis that was applicable to the service provided. The service must also ensure that there is an ongoing oversight of mandatory training for subcontracted staff. (Regulations 17(2))
- The service must ensure that safeguarding training, policies and process are in place. (Regulations 17(2))
- The service must ensure that incidents are well documented, follow a protocol and lessons learnt are shared with all appropriate staff. (Regulations 17(2)).
- The service must ensure that all staff files are up to date and that there are effective systems and processes in place to monitor radiology staff training, appraisals, indemnity insurance and revalidation. (Regulations 17(2)).
- The service must ensure that all staff have completed a Disclosure and Barring Service check. (Regulations 17(2)).

Action the service SHOULD take to improve:

- The service should ensure that patient information is kept in a secure space when stored at the radiologists reporting address with appropriate security measures in place to prevent patient data being stolen.
- The service should consider that equipment for reporting is in line with the seven key guidelines listed by the Royal College of Radiology (RCR).
- The service should ensure adherence to national guidance and evidence-based practice.
- The service should consider standardising reporting methods by having polices in place for radiologists to follow.
- The service should ensure a system for auditing is in place. The service should consider the quality of audits produced, firstly identifying the purpose of the audit and secondly organising the outcome, learning objectives and action plans in a clear and methodological manner.
- The service should consider increasing the level of audits produced.
- The service should consider who reviews the outcomes of the audits and ensure that they have the right expertise and clinical knowledge to interpret the results. The results should be shared with all radiology staff.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic and screening services	Inadequate	Inspected but not rated	Not inspected	Inspected but not rated	Inadequate	Inadequate
Overall	Inadequate	Inspected but not rated	Not inspected	Insufficient evidence to rate	Inadequate	Inadequate

Inadequate

Diagnostic and screening services

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

Are Diagnostic and screening services safe?

Inadequate

We rated it as inadequate.

Mandatory training

The service did not provide mandatory training in key skills to staff or made sure everyone completed it.

Staff employed did not receive and kept up-to-date with mandatory training. Staff said that most mandatory training was not applicable to the service that they were providing.

There was no mandatory training list of requirements that staff were expected do on an annual basis.

The registered manager had completed training in display screen equipment within the last 12 months.

We saw evidence that subcontracted staff had completed and kept up to date with mandatory training relevant to this service such as data security awareness (information governance) and safe information handling. The training was undertaken at the trust in which the radiologists worked full time.

Safeguarding

Staff did not have policies in place to report abuse.

The provider reported on adult and children's dental images.

Staff did not receive training specific for their role on how to recognise and report abuse. Staff said that safeguarding a patient would be difficult to ascertain as the service did not physically see patients.

Staff could give examples of abuse that could be seen on dental images.

Staff relied on the reporting radiologist to pick up safeguarding concerns such as dental trauma as they had the expertise to do this.

Subcontracted radiologists were up to date with their safeguarding training.

Inadequate

Diagnostic and screening services

Teleradiology providers do not see patients directly, so staff would not need the usual level of safeguarding training as expected of staff working directly with patients in a more typical radiology department. However, staff need basic safeguarding training as they might need to know how to raise a safeguarding concern.

There was no policy in place to make a safeguarding referral, but radiologist staff knew to inform the manager if they had concerns.

The provider forwarded all concerns highlighted by the radiologists to the referrer. The provider had not come across any reports that were indicative of a safeguarding concern. The manager was aware that all health professionals hold a responsibility for a patient.

There were no protocols to identify and verify the patient, but the service did identify patients using suitable patient identifiers such as their full name and date of birth.

Environment and equipment

The environment was suitable for the services provided; however, there were no oversight of equipment used for reporting.

The service had access to enough suitable equipment for diagnostic purposes. However, staff did not log or carry out safety checks of specialist equipment.

The provider had not documented or reviewed the radiologists working arrangements for reporting from their place of work which was their home. This included the environment for clinical review of images.

There was no oversight of radiologists reporting display monitors as well as no regular quality control and calibration programme of the display monitors. The provider placed the responsibility on radiologist to do this but did not ask for evidence that this had been done.

There are seven key recommendations on Picture Archiving and Communication Systems (PACS) and guidelines on diagnostic display, third edition, as listed by the RCR. Examples of these guidelines include having at least 3 megapixels resolution, a luminance range of at least 1-350 candelas per square meter which is regular hardware calibrated such that it remains within 10% of the digital imaging and communications in medicine (DICOM) grayscale standard display function (GSDF). The provider did not have evidence or formal assurance that radiologist were working within these RCR guidelines.

Assessing and responding to patient risk

The service had processes in place to respond to diagnostic reports received.

The service did not deal directly with patients regarding abnormalities or risk factors that may require additional support or intervention or changes to patient's care or treatment. All patient information was passed directly to the referrer. We saw an alert log which documented evidence that the provider sent the referrers an alert when unexpected findings were seen on a dental image.

The manager was able to check that all requests for medical exposures were justified by an Ionising Radiation (Medical Exposure) Regulation (IR(ME)R) practitioner. The manger checked that the referrer (practitioner) was registered with the General Dental Council (GDC). All medical exposures were undertaken by a dentist.

The manager made sure that each request for a report was justified, for example, asking for more detail when required. We saw evidence on this on an email trail.

Staffing

The service had enough staff to review and report dental images. However, we did not see evidence that the provider had gained assurance that they had the right qualifications, skills, training and experience.

The service subcontracted enough staff to support the needs of the service. The service had three radiologists to review and report dental images.

Radiologists received an automatic email when images were waiting for a review.

The manager had access to another tele radiologist provider for support when demand increased.

The provider had sight to some of the relevant information on the radiologists carrying out the regulated activity. This included the indemnity insurance, continual professional development, mandatory training and an up to date current curriculum. We did not see appraisals, GDC registration or original qualifications. The provider had not asked for a DBS check for the radiologists undertaking work for the company.

Records

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

Patient records were comprehensive, and staff could access them easily. Patient records were electronic and were complete.

Records were stored securely. Electronic records were secure and were password protected.

The service used the Picture Archiving and Communication System which was secure, and password protected.

The provider did not always adhere to the Royal College of Radiology (RCR) guidelines three standards.

Standard one: there should be clear and transparent systems in place for rapid, secure transfer and reviews of images and where necessary storage of patient data. The provider encouraged referrers to use Secure File Transfer Protocol (SFTP) to transfer patient data to the provider. The providers website detailed the benefits of using SFTP.

Standard two: reporting must be the same standard independent of where and by whom the data is reported. The provider did have a standardisation or expectation of the quality of the reports produced by the radiologists, but this was not always followed or enforced.

Standard three: the same person should interpret the examination and issue the report to the referring clinician and should be clearly identified, with the results communicated and integrated into the base hospitals radiology information system, picture archiving and communications systems and electronic patient record in a timely manner. The provider sent the dental images to one of three radiologists to interpret the examination and write a report. The

radiologist signed this report and could be identified by their initials on the report. The report and annotated images were sent back to the provider and the provider forwarded it to the referrer. The provider received an automated notification when the referrer had downloaded the reviewed images and report. The provider checked the quality of the report, looking for potential spelling mistakes before sending the report to the referrer.

Radiologists were able to access previous images and reports of patients on request. Images were kept on a hard drive in a secured commercial locked storage. This allowed for old images to be recovered if needed. The hard drive was password protected.

The provider also rented space on a server in Cork, in Ireland; for 12 months' worth of patient data and images. The manager was aware that GDPR in the EU (Ireland) matched the GDPR legislation in England. Images being sent outside the United Kingdom to Ireland for storage were in compliance with the GDPR.

Additional images were stored on a hard drive at the providers address. This hard drive had two security firewalls and it was password protected. The property was alarmed. Security measures in place were proportionate to the patient data held. The identifiable patient information on the images held the patients name and date of birth.

Radiologists were responsible for their own data security within their working environments as stipulated in their agreement. The provider had no assurance that the data security of the remote radiologists was acceptable.

Medicines

We did not inspect this element using our key lines of enquires as this was not applicable to this service. The provider did not dispense or administer any medicines as part of this service.

Incidents

The service did not manage incidents well. The manager did not investigate incidents or shared lessons learned. When things went wrong, the manager apologised and gave clients honest information and suitable support.

The registered manager knew what incidents to report. There were no reportable incidents in the last 12 months. The last incident that the manager could recall was in 2019. The manager was able to give examples of incidents that had occurred in the past and the actions taken as a result of these incidents. In one particular case regarding a misspelt name an email was used to resolve the incident. There was no other written documentation. The manager did not have a policy or protocol in place in the event of an incident.

The provider did not have a policy for reportable incidents or what constituted as an incident, serious incident, near miss or never event.

Staff did not receive feedback from investigation of incidents, both internal and external to the service.

There was no evidence that changes had been made as a result of feedback from an incident.

The service had no reported never events.

The manager did not share learning with their staff about never events that happened elsewhere.

Inadequate

Diagnostic and screening services

Staff understood the duty of candour. They were open and transparent and gave referrers and radiologists a full explanation if and when things went wrong. Should a patient get in contact with the provider should things go wrong the provider was able to extend a duty of candour to the patient. Patient contact was rare at this provider.

Are Diagnostic and screening services effective?

Inspected but not rated

We currently do not rate effective for teleradiology services.

Evidence-based care and treatment

The service did not provide evidence of working against national guidance and evidence-based practice.

There were no polices or protocols for the work carried out at IDT scans in relations to the regulated activities. Therefore, we could not be assured that image reporting adhered to national guidance or were in line with evidence-based practice.

The provider did not have an audit schedule in place to audit their work against guidelines from The National institute for Health and Care and Excellence (NICE), RCR guidelines or other relevant public bodies.

Peer reviews did not take place. Processes should be in place to notify a peer with feedback when necessary.

Nutrition and hydration

We did not inspect this element using our key lines of enquires as this was not applicable to this service.

Pain relief

We did not inspect this element using our key lines of enquires as this was not applicable to this service.

Patient outcomes

Staff did not monitor the effectiveness of their service.

The service did not participate in relevant national clinical audits.

The service did not carry out a comprehensive programme of repeated audits to check improvement over time.

The service did not have an audit schedule in place. The provider conducted informal monthly radiology reporting audits. We were able to view the last audit conducted, which was in January 2022. The audit results were incomplete and were not set out in an easy to follow format. Regulatory and external bodies looking at this audit would not be able to identify the purpose, the outcome, the learning objectives or an action plan as a result of this audit.

Inadequate

Diagnostic and screening services

We were not assured that outcomes for patients were positive, consistent and met expectations, such as national standards. The informal monthly audits allowed a small percentage of reported scans to be audited by a different radiologist. The registered manager would then compare the two reports to see if both reports held the same information. The registered manager did not have the clinical expertise to review the reports or the findings.

The service did not use the results to improve patients' outcomes. The service did not share or made sure staff understood information from the audits. The two radiologists involved did not see the results of the audit and only differences in the reports were flagged to the radiologists. This had not occurred so far. Therefore, it was difficult to ascertain if learning outcomes could be achieved.

The provider did not have an audit protocol or followed an audit process, this meant that it would be difficult to repeat the audit. Repeating audits determine whether actions taken have been effective or whether further improvements are needed.

We saw evidence that radiologists notified IDT scans of significant or unexpected findings. This was then escalated by IDT scans to the referrer by phone call or by email.

Competent staff

The service did not make sure staff were competent for their roles. Managers did not appraised staff's work performance or held supervision meetings with them to provide support and development.

We were not assured that staff were experienced, qualified and had the right skills and knowledge to meet the needs of their clients. We reviewed staff records and found that these were incomplete. We saw indemnity insurance, continual professional development, mandatory training and a current curriculum vitae (CV) for the three subcontracted radiologists. We did not see appraisals, GDC registration, or original qualifications. All radiologists reporting on patient images in the United Kingdom are required to be registered with a UK healthcare regulator and comply with their requirements for example, revalidation. The manager could not provide evidence that the three radiologists that reported for the service were registered with the GDC. We raised this with the manager who stated that their GDC pin numbers were on all the reports but the manager had not looked this up on the GDC website.

The manager had not requested to see Disclosure and Barring Service (DBS) checks on any of the three radiologists.

The company secretary did not have a DBS check, did not attended any mandatory training and did not have any additional learning needs identified to support them in their role.

We were not assured that managers supported staff to develop through yearly, constructive appraisals of their work. No appraisals took place at IDT scans.

The manager did not hold staff meetings. The manager did not hold formal staff meetings on a regular basis where updates could be shared or learning needs identified.

Managers did not ensure that staff received any specialist training. We saw no evidence of staff undertaking specialist training for their role. The manager did not provide a list of training required for staff to undertake.

The manager did not identify poor staff performance and did not support staff to improve. When referrers identified that more information was required on a report, the manger would change the radiologist used for that referrer the next time a report was referred from that provider.

Inadequate

Diagnostic and screening services

The systems in place to monitor contracted staff's training, appraisals, indemnity insurance and revalidation were not effective. Records were not fully complete and there was no evidence of Disclosure and Barring Service (DBS) checks for staff used by the service.

The service provided us with evidence to show tele radiologists had completed their continued professional development (CPD) in line with the royal college of radiologists (RCR).

The service employed a company secretary. We spoke with the company secretary who confirmed that they were unable to fully participate in their work at IDT Scan for a period of time as they had some personal issues. This included undertaking mandatory training including training in general data protection regulation (GDPR).

Multidisciplinary working

Staff worked in silos completing individual tasks and managing their workload.

Due to the nature of the service, and radiologists working remotely, there was very limited contact with each other. However, we saw email communications between the radiologist and the registered manager.

Requests for reports from dentists included patient demographics and clinical details of patients. Where clinical details had been insufficient IDT scans had followed up with the dental referrer to request more information.

Referrers had the option to speak directly to the radiologist for advice over phone or via email.

Seven-day services

The service did not provide a seven day teleradiology service.

The service worked Monday to Friday 7am to 5pm.

Health promotion

We did not inspect this element using our key lines of enquires as this was not applicable to this service.

Consent and Mental Capacity Act

We did not inspect this element using our key lines of enquires as this was not applicable to this service.

Are Diagnostic and screening services responsive?

Inspected but not rated

We inspected this Key Question but have not rated it.

Service delivery to meet the needs of local people

The service planned and met the needs of the clients using the service.

The managers planned and organised the service so that it could meet the needs of the providers using the service.

The service worked Monday to Friday 7am to 5pm.

The manager monitored and took action to minimise delays in turnaround times for reporting. We saw evidence that radiologists were contacted to ensure that reports were delivered within the three to five day reporting turnaround time. The manager kept clear communications with the referrer should there be a delay. Referrers were easily able to contact the provider for reports.

The manager told us that there was a 95% target for meeting all report targets. The manager achieved a 94% target in the last quarter, no actions on how to improve this target was discussed.

Access and flow

Clients could access the service when they needed it.

The service used picture archiving and communication system (PACS) which supported tele-radiologists to upload and submit their reports safely and securely. Radiologists received a notification when they had pending images waiting for review.

Radiologists received a template report, along with the images which stated the urgency of which the report was required and the patients name and date of birth.

Referrers were able to state how quickly they required a report and were given a choice between three and five working days. There were options for a tighter turnaround time at an additional cost.

The manager used another teleradiology service for overflow of reports and to ensure that timelines were met. The manager had a formal agreement in place with this provider but did not observer any audits on the quality of work produced by this provider.

The service had a contingency plan should there be a disruption in the service. The provider had four major customers and had the contact details of these providers in the plan. The service would use automated email replies to inform other providers of a break in service.

Learning from complaints and concerns

It was not clear how clients could give feedback and raise concerns about reports received.

The service did not clearly display information about how to raise a concern on their website, which was the main method of relaying information to clients.

There was no policy on complaints, but the manager stated they knew how to handle them and resolve any arising issues.

The manager did not share feedback from complaints with radiology staff to improve the service.

The manager reported no complaints in the last 12 months. The last complaint received was over two years ago. Complaints received were kept in a detailed complaints log, and actions for justified complaints were documented. All complaints were resolved in a timely manner.

Inadequate

Diagnostic and screening services

The manager was able to match the referrers' expectations with individual radiologists and their style of reporting. This could only be done once a report had gone back to a referrer and the referrer made additional requests such as more written detail required or more detail needed highlighting particular aspects of the dental images. There was no enforced standardised method for reporting.

Are Diagnostic and screening services well-led?

Inadequate

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They did not support staff to develop their skills and take on more senior roles.

The manger had the skills and abilities to run the service but did not have the expertise to spot mistakes or question the work produced. The manager attended international conferences and workshops relevant to their role, read journals and produced reflection statements for their continual professional development. This was well documented and sent to the Irish College of Physicists in Medicine on an annual basis.

The manager understood the needs of the business and put clients and radiologists first.

The manager was not physically visible but was contactable by phone and email.

Vision and Strategy

The service did not have a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

There was no formal vison or a set of values, with quality or sustainability as the top priorities. When we asked the manager what the vision was the manager replied that the main philosophy was to stay small and to do the job well, putting quality first.

There was no robust, realistic strategy for achieving the businesses priorities or to deliver good quality sustainable reporting.

Culture

Staff felt respected, supported and valued.

Staff we spoke with felt respected and valued and spoke highly of their manager. The culture was centred on the needs of the people who used the service. Staff we spoke with felt positive and proud to work for the provider. The culture encouraged openness and honesty at all levels within the organisation.

The service did not provide mechanisms for all staff with the development they need, including high-quality appraisals and career development conversations.

There was a strong emphasis on the safety and wellbeing of staff.

Inadequate

Diagnostic and screening services

Governance

The manager did not operate effective governance processes, throughout the service and with partner organisations.

We were not assured that leaders had the appropriate knowledge base to conduct audits to measure the quality and accuracy of the work produced.

There were no systems in place to monitor staff's training, appraisals, and indemnity assurance. Staff records were incomplete, and the manager had not asked to view DBS checks for any staff member. There were no effective systems in place to capture this data or to check the validation of the information held by the service for each staff member.

There was a complete oversight of mandatory training applicable to the service provided. There were no additional on-going training needs or learning identified, specific to the service provided.

On the day of inspection, we saw evidence of indemnity insurance for all of the reporting radiologists. Effective systems and processes were in place to monitor if reporting radiologists had the indemnity insurance in place.

The provider did not have processes in place to effectively assess, monitor and improve the quality of the service. The provider had not developed policies, procedures or enforced standards for reporting.

The provider did not have monthly meetings to discuss performance, wellbeing or difficult cases.

Management of risk, issues and performance

The manager identified relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The manager identified potential risks and provided a mitigating action to all risks. There was a contingency plan in place for IT failures. For example; if there was a computer break down, there were two identical workstations which could be substituted in under an hour. There was also a spare monitor. Also, if the telephone line was disconnected calls would be automatically diverted to a mobile phone.

There was no formal process for informing clients of any disruptions to the service, but the contingency plan had all the relevant client details to do this.

The provider had identified and assessed risks to the business and had a risk register.

Information Management

The service did not collect reliable data or analysed it.

The service provided electronic access to diagnostic results for reporting radiologists.

The manager would send a text reminder to radiologists the day before the report was due. The manager kept track of service performance measures and had a 95% target for reporting in line with the 3 to 5 day turnaround time.

All communications with the referrer was done by email or phone call. Communications were quick and simple.

Inadequate

Diagnostic and screening services

The information being sent between the referrer and the service was GDPR compliant. The information was not encrypted between referrer and the service. There are no explicit GDPR encryption requirements.

Data collected from the service was sparse or incomplete, this meant that staff could not understand performance or make decisions on how best to improve the service.

Engagement

The managers actively and openly engaged with organisations to plan and manage services. They did not collaborate with partner organisations to help improve services for patients.

The manager told us that there were regular communications with their clients to help manage and meet expectations.

The service did not have formal processes in place to receive feedback from providers that they obtained dental images from. However, the manager stated that they were open to feedback from both dentist referrers and radiologists.

The service had very limited contact with patients, despite this the service had a support page dedicated for patients on their website. The page was detailed, and the information provided was easy to read and follow.

Learning, continuous improvement and innovation

The service was not committed to continually learning and improving the service. Leaders did not encourage innovation and participation in research.

The manager attended events and meetings through the RCR network, where opportunities arose to meet and network with similar providers and also radiologists.

The managers did not show ambition for, improvement or innovation. The service did not participate in appropriate research projects or recognised accreditation schemes.

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17(2) The provider does not have systems or processes that enables the registered manager to: • Assess, monitor and improve the quality and safety of the services provided, such as regular audits. • Assess, monitor and mitigate the risks relating to health, safety and welfare of service users. • Maintain securely, necessary records to be kept in relation to persons carrying on the regulated activity. • Seek and act on feedback from relevant persons for the purposes of continually evaluating and improving. • Review training, professional development, supervision and appraisals with radiologists to enable them to carry out their duties.