West London Diagnostic Limited

West London Diagnostic Limited

Inspection report

66-68 South Ealing Road
London
W5 4QB
Tel: 07868724910

Date of inspection visit: 18 November 2022
Date of publication: 06/01/2023

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

Ratings

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

Summary of findings

Overall summary

We rated the provider as requires improvement because:

- The provider did not have a full anaphylaxis kit in a grab bag containing all of the required medicines.
- The service had improved its infection control practices since the last inspection however, we found a used glove in the medical trolley.
- We found out of date equipment that was not required for the procedures undertaken at the service, in the medical trolley.
- We found a sharps bin which had not been signed with its lid open which did not follow NICE guidance around the safe use and disposal of sharps.
- The service's policy for the scanning of children now made clear that the service did not undertake interventional procedures for children however it did not make clear that the service treated children who were 12 years old and above and we did not see a consent policy for children.
- The medicines management policy had been updated since the last inspection but the changes the service made as a result of the inspection had not been incorporated into the document.
- The service had improved its risk register outlining the risks to the service specifically however not all of the risks we found at the last inspection and this inspection were listed within the risk register.
- The service had a vision for what it wanted to achieve, however, the strategy still did not detail how the service planned on achieving these goals.
- The service did not have access to an interpreter for patients whose first language was not English but were in the process of sourcing a suitable interpreter service.
- The clinic was based within a building that was not easily accessible for wheelchair users. There was ramp to get into the clinic, but the patient toilets were too narrow to accommodate wheelchair users.

However:

- The service had ensured the ultrasound machine was serviced and PAT tested.
- The service had improved its infection control practices. There was now a cleaning log for the ultrasound machine, clinic room, chairs and examination couch.
- The service had actioned the National Patient Safety alert in relation to the safe use of ultrasound gel to reduce infection risk.
- The service had implemented temperature monitoring of the medicines cupboard.
- The service now had formal governance and team meeting minutes containing detailed discussion and actions.
- The service had amended the complaints policy to ensure that the CQC's remit was corrected reflected.
- Staff spoke highly of the manager.
- Patient records were comprehensive and clear.
- The service now had written clinical protocols and policies in place.
- The service now had a comprehensive audit schedule and had begun undertaking quality assurance for the ultrasound machine.
- The service's safeguarding policy now referred to up to date versions of national guidance and contained details on how staff can make a safeguarding referral.
- The registered manager was clear on the requirements of a practising privileges policy and now ensured that the service followed its practising privileges policy.

Summary of findings

On 14 September 2022, West London Diagnostic Limited was issued with an urgent notice to suspend their registration as a service provider in respect of regulated activities. This notice was served under Section 31 of the Health and Social Care Act 2008. We re-inspected the service on 18 November 2022 and found that the service had made significant improvements in the areas where we had concerns. Action we have asked the provider to take can be found at the end of this report.

Summary of findings

Our judgements about each of the main services

Service	Rating		Summary of each main service
Diagnostic imaging	Requires Improvement		West London Diagnostic Limited is a diagnostic service that provides ultrasound scans of the abdomen, pelvis and musculoskeletal scans including ultrasound guided steroid injections from consultant radiologists (to provide pain relief treatments). The service treats patients over the age of 18 years and children over the age of 12 years. The service did not carry out interventional procedures on children. The service is located in West London, Ealing. The service shares its location with a physiotherapy clinic, and shares staff such as domestic and reception staff. The service is operational between the hours of 5.30pm and 7.30pm, on Friday evenings. The provider sees self-paying patients who are mainly from West London, with a few patients from outside London.

Summary of findings

Contents

Summary of this inspection

	Page
Background to West London Diagnostic Limited	6
Information about West London Diagnostic Limited	6

Our findings from this inspection

Overview of ratings	8
Our findings by main service	9

Summary of this inspection

Background to West London Diagnostic Limited

West London Diagnostic Limited is a diagnostic service that provides ultrasound scans of the abdomen, pelvis and musculoskeletal scans including ultrasound guided steroid injections from consultant radiologists (to provide pain relief treatments). The service treats patients over the age of 18 years and children over the age of 12. The service did not carry out interventional procedures on children.

The service is located in West London, Ealing. The service shares its location with a physiotherapy clinic, and shares staff such as domestic and reception staff. The service is operational between the hours of 5.30pm and 7.30pm, on Friday evenings. The provider sees self-paying patients who are mainly from West London, with a few patients from outside London.

The service is registered with the CQC to provide the regulated activity of diagnostic and screening procedures and treatment of disease, disorder or injury.

At the time of our inspection the clinic employed one registered manager who was also the main consultant radiologist, one consultant, one healthcare assistant staff member and one administrative staff member.

In the last 12 months the service carried out 210 ultrasound scans on patients. Of these, 89% were musculoskeletal scans, 11% were for scans of the abdomen/kidneys/renal/testes.

How we carried out this inspection

We carried out a short notice announced comprehensive inspection on 18 November 2022 using our comprehensive methodology.

The inspection team comprised a lead CQC inspector and a specialist advisor. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection for London.

During this inspection, the inspection team spoke with the registered manager, the healthcare assistant, and a consultant.

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

Areas for improvement

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

Action the service MUST take to improve:

Summary of this inspection

- The service must ensure there is a full anaphylaxis kit in a grab bag containing all of the required medicines. (Reg 12 2a)
- The provider must ensure only equipment required for the procedures undertaken at the service is stored at the service and that all equipment is in date and used equipment is disposed of appropriately. (Reg 12 2a, b)
- The service must ensure it follows national guidance in relation to the safe use and disposal of sharps. (Reg 12 2h)
- The service must have an effective process for identifying, recording and acting on risk to keep patients safe. (Reg 17 2a)
- The service must ensure policies are updated to reflect all the changes the service has made. (Reg 17 b)

Action the service SHOULD take to improve:

- The service should ensure there is access to an interpreter for patients whose first language is not English.
- The service should ensure it embeds new processes such as audits, appraisals, ultrasound quality assurance, cleaning regimes and temperature log monitoring.
- The service should ensure medicines stored are correctly secured and at the correct recommended manufacturer's temperature.
- The service should ensure that a screen is available for patients to use to get changed behind to maintain their privacy and dignity.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Requires Improvement	Inspected but not rated	Insufficient evidence to rate	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Inspected but not rated	Insufficient evidence to rate	Requires Improvement	Requires Improvement	Requires Improvement

Requires Improvement

Diagnostic imaging

Safe	Requires Improvement
Effective	Inspected but not rated
Caring	Insufficient evidence to rate
Responsive	Requires Improvement
Well-led	Requires Improvement

Are Diagnostic imaging safe?

Requires Improvement

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff who worked at the service were also employed within the NHS and were able to demonstrate full compliance with mandatory training provided through their NHS posts.

Staff completed mandatory training which included but was not limited to; safeguarding, dementia awareness, learning disabilities, information governance, basic life support, equality and diversity, infection, prevention and control, health and safety and falls awareness. The mandatory training was comprehensive and met the needs of patients and staff. The service used online and face to face training.

The registered manager kept a record of mandatory training compliance rates which showed 100% compliance.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse. The safeguarding policy now referenced up to date versions of national guidance and contained instructions on who staff needed to contact to make a safeguarding referral.

Staff received training specific to their role on how to recognise and report abuse. Clinical staff were trained to level three for children and adult safeguarding. Staff we spoke with knew how to identify adults and children at risk of, or suffering, harm and where to make safeguarding referrals.

Requires Improvement

Diagnostic imaging

At our last inspection we found that the safeguarding policy referred to an out of date version of the Working Together to Safeguard Children national guidance from 2010 and did not include contact details or instructions on how to report safeguarding concerns. At this inspection we reviewed the policy which reflected up to date guidance and included instructions on how to and who to contact to report safeguarding.

The service had not had to make any referrals in the last 12 months.

Cleanliness, infection control and hygiene

The service had improved its infection control practices. There was now a cleaning log for the ultrasound machine, clinic room, chairs and examination couch. However, we found a used glove in the medical trolley.

We saw that the ultrasound machine was visibly clean and there was now a cleaning log to indicate when the machine had last been cleaned.

At our last inspection we found that there was no cleaning log for the clinic room, chairs or examination couch. At this inspection, we saw that there was a cleaning log for the clinic room which included cleaning checks for equipment such as the examination couch, computer station and chairs.

A domestic cleaner was employed to clean clinic rooms, toilet and waiting areas but at our last inspection we did not see cleaning logs for these areas. At this inspection, we saw cleaning logs for each of these areas that had been filled in and were up to date.

At our last inspection we found that ultrasound gel was being decanted from a big tub into old bottles which were dated with old dates. The service was unaware of the National Patient Safety Alert (NPSA) released in November 2021 which alerted services that "non-sterile gel should not be decanted from larger gel containers. Gel bottles should be dated when opened and used within one month, unless the expiry date is earlier." The act of decanting the gel into the bottle posed an infection control risk as there is a risk of cross contamination and there was also an infection control risk from the gel to the probe due to gel being decanted into the bottle. At this inspection we saw that the service no longer decanted gel and used single-use ultrasound gel bottles. Bottles we checked were in date.

We saw that disposable paper towel roll was used to cover the examination couch. This was changed, and the couch was cleaned between scans.

However, we found a used glove in one of the drawers of the medical trolley which meant that the contents of the drawer would have been contaminated. We raised this with the provider who took immediate action and cleaned out the entire medical trolley.

There was access to hand sanitisers, and we saw handwashing posters above the sink in the clinic room. Staff used personal protective equipment (PPE) and we saw that staff were bare below the elbow. At our last inspection, we observed that although staff used gloves and used new gloves for each patient, they did not wash their hands after each patient. Although we did not see patient care at this inspection, staff were able to correctly describe to us that they would wash their hands after each patient.

The service did audit hand hygiene on a monthly basis. The most recent hand hygiene audit for August 2022 showed compliance was at 79%. Actions were in place to address issues identified in the audit.

We reviewed the infection control policy which had been updated to reflect COVID-19 related precautions.

Environment and equipment

The environment was suitable for the service provided. The provider had improved their oversight of the equipment used for reporting. The ultrasound machine had now been serviced and now had portable appliance testing. However, we found out of date equipment that was not required for the procedures undertaken at the service, in the medical trolley.

The service had access to enough suitable equipment for diagnostic purposes. At our last inspection staff did not log or carry out safety checks of specialist equipment and we found that the ultrasound machine had not been serviced. At this inspection we saw that the ultrasound machine had been serviced and safety checks of specialist equipment were carried out by staff carried out before every session.

At our last inspection we found that the ultrasound machine had not had a portable appliance test (PAT). Electrical equipment should be examined regularly to ensure it is safe to use. At this inspection, we saw that the ultrasound machine had been portable appliance tested.

At our last inspection we found that the service did not undertake quality assurance for the ultrasound machine. This meant that the service was not ensuring that consistent, reliable results were provided and there were no checks for deterioration of equipment performance; this could negatively impact on service user safety. At this inspection, we saw that the service had implemented a quality assurance process for the ultrasound machine. Staff were able to explain how and when they carried out quality assurance checks and we saw that the service had a policy in place which outlined the quality assurance levels and checks undertaken.

At our last inspection we found that the sharps bin was full and had not been signed or dated and did not follow NICE guidance around the safe use and disposal of sharps. At this inspection we saw that the sharps bin was dated but not signed and the lid had not been closed. We were told that the sharps bin was shared with other occupants at the same location. Following the inspection, the service took immediate action by ordering a sharps bin that was dedicated to the service so that this could be monitored effectively.

We found that the medical trolley contained equipment that was not required for the type of procedures being carried out at the service. Some of the equipment was out of date. We raised this with the provider who took immediate action to remove the items from the trolley. This was a risk because out of date equipment can deteriorate over time and not be effective if used. In addition, some of equipment in the trolley were not required for the types of procedures undertaken at the service.

The service had a service level agreement with the physiotherapy clinic with which it shared its premises for a waste management company to collect clinical waste.

Staff kept substances which met the Control of Substances Hazardous to Health (COSHH) regulations in a locked cupboard in a room accessible by staff only. We saw that these were stored appropriately.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. The service now had a deteriorating patient policy.

Diagnostic imaging

Staff completed risk assessments for each patient at the point of booking and on arrival. The service used a 'pause and check' system, as per guidance from the British Medical Ultrasound Society.

The consultant radiologist checked the full name, date of birth and first line of address with patients, as well as checking the site or side of the patient's body that was to have images taken and the existence of any previous imaging the patient had received.

The service treated medically stable patients. At our last inspection the service did not have a deteriorating patient policy which meant that there was no documented policy for staff to follow in the event a patient deteriorated. At this inspection we saw that the service had a comprehensive deteriorating patient policy with instructions for staff to follow.

All patients underwent the risk assessment and gave verbal and written consent to the diagnostic test before their scan.

We were told by the consultant radiologist that any unexpected or significant findings from image reports were escalated to the referrer. Staff told us that dependent on the findings, patients may need to go to the local accident and emergency department. The service had an unexpected findings pathway which detailed what staff should do if there was an unexpected finding on a scan.

The service did not undertake interventional procedures for children and now had a specific policy for the scanning of children. However, the policy did not make clear that the service scanned patients 12 years old and above. Following the inspection, the service submitted an updated policy with the age of patients clearly defined.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough clinical and support staff to keep patients safe. The registered manager was the main consultant radiologist at the clinic and was supported by a healthcare assistant who also acted as a chaperone. The service employed one other consultant and an administrative staff member. The service did not use bank or locum staff.

In the event of sickness, the service rescheduled appointments. The service had not had to cancel any appointments due to staffing shortages or sickness in the 12 months preceding our inspection.

Records

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

Patient records were comprehensive and staff could access them easily. Records were stored electronically in a secure cloud-based system which was password protected.

Patient records included the referral form, consent form and scan images. All patient data, medical records and scan results were documented on the secure patient electronic record system. Scan reports were emailed to the patient and their GP as a password protected document.

Diagnostic imaging

Patients were given an information leaflet which contained a summary of the procedure undertaken and patients seen for musculoskeletal pathways were emailed a pain diary so they could record pain scores in the following days and weeks after treatment. They were then advised to return the form to their GP or referrer so they could to track the patient's progress.

Medicines

The service had improved systems and processes to safely store medicines. They also now had a medicines management policy which was specific to the clinic's activities. However, the policy had not included the changes the service had made since the last inspection.

At our last inspection, we found that there was no medicines management policy specific to the clinic's activities. At this inspection we saw that the service had an updated medicines management policy specific to the clinic's activities and included information around the recording, handling, storage and security, dispensing, safe administration and disposal of the medicines held at the clinic. However, the policy had not included the changes the service had made since the last inspection.

Following the inspection, the provider sent through an updated policy which included details about the changes made since the last inspection.

Medicines were now stored in a locked cupboard in another room. Staff checked the temperature of the medicines cupboard when they used the clinic which was once a week.

During this inspection we found that the service did not have a full anaphylaxis kit kept in a separate grab bag for ease of access. This was a risk to patients as the service did not have all of the medicines required in the event a patient had an allergic reaction. When we raised this with the provider, they took immediate action and ordered a full anaphylaxis kit on the day of inspection.

The provider did have a logbook where they recorded when medicines had been used and stock was checked.

Medicines used in patients' procedures were clearly listed in the patient records. We saw in patient records that allergies were clearly documented within their record. The service did not dispense medicines for patients to take away with them. The clinic did not utilise or store controlled drugs.

Incidents

Staff recognised incidents and near misses and knew how to report them.

Staff knew what incidents to report and how to report them. The service had an incident reporting log and an incident reporting policy. There were no incidents reported in the last 12 months. The registered manager told us that in the event of an incident, they would investigate the incident thoroughly and share learning and feedback with the team.

Staff understood the duty of candour. They told us they would be open and transparent, apologise and give patients and families a full explanation if and when things went wrong.

Requires Improvement

Diagnostic imaging

Are Diagnostic imaging effective?

Inspected but not rated

We do not rate effective for diagnostic services.

Evidence-based care and treatment

The service was now able to provide evidence of policies using national guidance and evidence-based practice.

The service now had clinical policies and written protocols relating to the scans undertaken at the clinic. Policies reflected national guidance such as British Medical Ultrasound Society (BMUS) Guidelines and National Institute for Health and Care Excellence (NICE) guidance.

At our last inspection, the service did not undertake quality assurance for the ultrasound machine for Level 1, 2 and 3 as per British Medical Ultrasound Society (BMUS) Guidelines. At this inspection, the service had implemented quality assurance for the ultrasound machine for Level 1, 2 and 3. There are three levels of quality assurance: Level 1 Infection control and scanner damage; Level 2 Basic scanner and transducer testing; Level 3 Further scanner and transducer testing. This meant that the service could now ensure that consistent, reliable results were provided by the machine and deterioration of equipment performance could be monitored.

Nutrition and hydration

Due to the nature of the service, staff were not required to provide patients with food and drink to meet their needs and improve their health. Drinking water was available for patients.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain before, during and after the procedure. They used a recognised tool to assess pain where patients could give a score between zero (no pain) and 10 (severe pain). Patients were directed to their GP if they required pain relief. Patients were also given a pain diary so they could record pain scores in the following days and weeks after treatment. They were then advised to return the form to their GP or referrer so they could to track the patient's progress. The provider has also made the pain diary accessible electronically so that results could be audited.

Patient outcomes

The provider had improved systems to monitor the effectiveness of their service.

Diagnostic imaging

At our last inspection, the service did not have a comprehensive programme of repeated audits to check improvement over time. At this inspection, the provider had implemented a comprehensive audit schedule to audit their work using the guidelines from the National Institute for Health and Care Excellence (NICE) or British Medical Ultrasound Society guidelines. A peer review system was now in place for consultant radiologists.

At our last inspection the service audited patient feedback and hand hygiene but did not conduct other audits. Although the auditing was in its early stages since the last inspection, we saw schedules of audits set out to be carried out throughout the year. The audit schedule detailed the type of audit and the staff member assigned to carry out the audit. Audits included, an independent audit of scan reports, infection, prevention and control, WHO checklist, patient satisfaction, pain diaries and hand hygiene. There was now a process in place for the peer review of scan reports to gain assurance that scan procedures were carried out in line with the service's policies.

The service was able to demonstrate that it participated in the national clinical audit for patient reported outcome measures (PROMS). At our last inspection it was not clear if outcome data was reviewed or discussed with the clinic team and if learning was shared. At this inspection we saw that the service had built into their governance meeting templates, discussion of audit outcomes.

Competent staff

The service made sure staff were competent for their roles.

The service employed an administrative member of staff who completed bookings, a healthcare assistant who also acted as a chaperone and two consultant radiologists (including the registered manager). Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The registered manager gave all new staff a full induction tailored to their role before they started work.

Radiologists had received competency-based training as part of their substantive NHS roles and maintained their individual competencies as part of their continuing professional development (CPD) certification. All details of training were held within personnel files. Both consultants had immediate life support training.

At our last inspection, there was no evidence that the registered manager supported staff to develop through yearly, constructive appraisals or supervision meetings of their work. Staff did not have an opportunity to discuss training needs with their manager. At this inspection we were told that appraisals for staff had now been arranged.

We reviewed staff records and found that these were complete. We saw indemnity insurance, continuing professional development, appraisals for consultants, current Disclosure and Barring services checks and a current curriculum vitae (CV) for all staff.

The registered manager now held formal staff meetings which took place monthly. Meeting minutes were detailed containing learning and action points.

Multidisciplinary working

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

Staff worked together as a team to benefit patients. We observed good working relationships between the healthcare assistant and the consultant radiologist.

Requires Improvement

Diagnostic imaging

Staff commented on good team working and spoke of informal meetings where they would be able to catch up with the manager.

The clinic had good relationships and established referral pathways with local NHS services where patients were referred to if there was an unexpected finding. The consultant radiologist ensured that patients received timely care when referred, by ensuring that scan reports were sent immediately to the receiving service.

Seven-day services

The service did not provide a seven day service.

Due to low activity, the clinic was open on Fridays between 5:30pm and 7:30pm.

Health promotion

The service had limited opportunities to be involved in promoting healthy lifestyles.

Staff assessed each patient’s health at the appointment and said they would signpost patients to their GP should they require any support to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff received and kept up to date with training in the Mental Capacity Act.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. This included written and verbal consent. Records we reviewed, showed that staff clearly recorded consent.

The service saw children over the age of 12 years old. A parent or guardian was required to accompany the child. Staff we spoke with understood Gillick competence but we did not see a policy for this.

Are Diagnostic imaging caring?

Insufficient evidence to rate

Insufficient evidence to rate

Compassionate care

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

Requires Improvement

Diagnostic imaging

At the time of our inspection, the service did not see any patients so we were unable to observe patient treatment.

Staff told us there was always a chaperone during a procedure.

At our last inspection we noted that there was no screen available in the clinic room for patients to get changed behind to maintain their privacy and dignity. We were told by staff that they would leave the room to allow patients to change.

Emotional support

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

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff told us how they would explain procedures to patients to support them to make informed decisions about their care.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

An online patient feedback questionnaire was sent to patients after their appointment.

Prices of treatment were discussed prior to an appointment and they were also listed on the service's website.

Are Diagnostic imaging responsive?

Requires Improvement

Our rating of responsive stayed the same. We rated responsive as requires improvement.

Service delivery to meet the needs of local people

The service planned and met the needs of service users.

The registered manager planned and organised the service so that it could meet the needs of patients. Due to low activity, the service operated on Friday evenings from 5.30pm to 7.30pm. Each appointment was scheduled to last half an hour to give patients ample time to ask questions. Patients commented that evening appointment slots were helpful for them as they were able to attend after work.

Meeting people's individual needs

Diagnostic imaging

Staff made some reasonable adjustments to help patients access services however the building that the clinic was located in was not wheelchair friendly. The service did not have an interpreter service for patients whose first language was not English.

Staff understood and respected people's personal, cultural, social and religious needs, and to take these into account.

The clinic was based within a building that was not easily accessible for wheelchair users. There was ramp to get into the clinic, but the patient toilets were too narrow to accommodate wheelchair users.

Patient information leaflets and patient questionnaire papers were available only in English. The service did not have access to an external interpreter service for patients whose first language was not English. However, the registered manager told us they were in the process of sourcing a suitable interpreter service.

The clinic did not treat patients with complex health conditions or learning disabilities.

Access and flow

People could access the service when they needed it and received the right care promptly.

The registered manager worked to keep the number of cancelled appointments and treatments to a minimum. The service had not needed to cancel appointments in the last 12 months due to staffing issues. Patients were able to change their appointment slots easily by calling the booking team and rearranging their appointment date.

The registered manager monitored and took action to minimise delays in turnaround times for reporting. The turnaround for scan reports was one working day. The registered manager told us that scans that were undertaken on a Friday would usually be sent over to the referrer over the weekend or on Monday at the latest. The manager kept clear communications with the referrer should there be a delay and referrers were easily able to contact the provider for reports. However, the service told us that they met their KPI 100% of the time.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service had updated its complaints policy since the last inspection.

The service provided various ways for patients to give feedback. The service had paper questionnaire forms available in the clinic as well an online feedback form that patients could fill out.

There were posters in the clinic on how to make a complaint or feedback and staff understood the procedures around handling a complaint. Staff told us they had not received any complaints in the last 12 months but would try to resolve concerns when they were raised.

At our last inspection, the service's complaints procedure for patients indicated that patients could ask the CQC for an independent review of their complaint if they are unsatisfied with the service's response. This is not within the CQC's remit as the CQC does not investigate individual complaints. At this inspection we saw that the complaints policy had been updated to correctly reflect the remit of CQC. The service had also subscribed to an independent adjudication service that could support investigating complaints objectively when they could not be resolved locally.

Requires Improvement

Diagnostic imaging

Are Diagnostic imaging well-led?

Requires Improvement

Our rating of well led improved. We rated well led as requires improvement.

Leadership

Leaders were visible to staff and understood the priorities of the service. Leaders now had full oversight of the service's policies.

The registered manager was the lead consultant radiologist and was responsible for the day to day running of the clinic.

They received support from an external company which managed IT support and administrative support.

At our last inspection we found that the registered manager was focused on the clinical care provided at the service and did not demonstrate an understanding of the obligations placed on them by their role as a CQC registered manager or the fundamental standards of care. At this inspection the registered manager was able to demonstrate an improved understanding of their obligations placed on them and the fundamental standards of care.

The registered manager had now implemented an appraisal system for staff so that they could support staff to develop their skills. Plans were in place to undertake the appraisals in the new year.

The registered manager was also now clear about the requirements of a practising privileges policy. There was a practising privileges policy was now in place in addition to a standard operating procedure outlining the process for staff who apply for practising privileges at the provider. The service had also implemented a tracker to regularly review clinicians' practising privileges as per policy. We reviewed the practising privileges of a staff member and found all paperwork to be in place as per policy.

Vision and Strategy

The service had a vision for what it wanted to achieve, however, the strategy still did not detail how the service planned on achieving these goals.

The service had a vision which was to provide affordable scans and treatment for patients in the local community. The service had a documented 'vision and strategy' policy which laid out short and long term plans with a focus on quality and safety for the short term and to expand the business and open other locations as a long term plan. However, the strategy did not detail how the service planned on achieving these goals.

Staff we spoke with knew about the vision of the service.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Diagnostic imaging

Staff we spoke with felt respected and valued and spoke highly of the registered manager. The culture was centred on the needs of the people who used the service. All staff, including medical staff, we spoke with were positive about working at the provider and commented that the registered manager was very approachable and communicated with the team well.

Governance

The registered manager had made improvements to the service's governance processes. However, although oversight of policies had improved, there were still some policies that did not include sufficient information.

At our last inspection we found that the provider did not have processes in place to effectively assess, monitor and improve the quality of the service. The service relied on informal sharing of information.

At this inspection we saw that the registered manager had implemented a number of new processes to assess, monitor and improve the quality of service. For example, there were now formal governance meetings which took place quarterly with a comprehensive list of agenda items such as risk register updates, complaints, patient feedback, incidents, mandatory training compliance, medicines management, infection control and audit results.

However, as the service had been suspended, we could not gain evidence to say that these processes had been embedded or were sustainable.

We viewed the latest monthly team meetings which were now comprehensive and detailed with actions in place. Staff we spoke with were able to describe the changes made since the last inspection.

The service now had clinical policies which reflected up to date national guidance relating to the scans undertaken at the clinic.

At our last inspection we found that some of the provider's policies such as the safeguarding policy, practising privileges policy and complaints policy, did not contain up to date guidance, reflected incorrect information, or was not sufficiently detailed. At this inspection, we saw that these policies had been updated, included sufficient detail and reflected correct information. However, the medicines management policy and child scanning policy did not detail all of the changes made since the last inspection and there was a lack of consent policy for children. The service submitted updated versions of these policies following the inspection.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. However, not all risks were identified within the service's risk register.

At our last inspection staff told us the service did not undertake routine clinical governance audits to identify changes that would improve the service. At this inspection, the service had comprehensive audit programme to ensure that they could monitor the effectiveness of the service and identify improvements. Staff had now been assigned to carry out certain audits.

Requires Improvement

Diagnostic imaging

At our last inspection we found that the service's risk register only identified environmental risks of the building rather than risks specific to the service. At the inspection we saw that the service had updated their risk register to reflect specific risks to the service. However, not all of the risks we had identified at the last inspection and at this inspection had been included. Following the inspection, the service submitted an updated risk register which included all risks identified at the last inspection and this inspection with mitigations and risk owners in place.

The service did have a documented business continuity plan in place for major incidents such as power failure or building damage. The service did not have a back-up generator but if there was a power outage, the registered manager told us that appointments were cancelled and rescheduled.

Information Management

The service collected reliable data and was able to analyse it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service had systems to collect reliable data and could use it to analyse performance, make decisions and improvements. However, as the service had been previously suspended, we had not yet seen evidence of this.

Staff received training for information governance and the General Data Protection Regulations. Computer terminals were password protected, and the scanning machine was also password protected.

There were effective arrangements to ensure the confidentiality of patient identifiable data. Computer stations we saw were logged out when not in use. The electronic booking system and customer database were maintained on a secure, encrypted cloud-based server.

The service was registered with the Information Commissioner's Office (ICO), the UK's independent authority set up to uphold information rights.

The service had appropriate and up-to-date policies for managing personal information that were in line with relevant legislation and the requirements of the General Data Protection Regulations.

Engagement

Leaders and staff actively and openly engaged with patients.

The service used patient feedback to guide the service delivery and responded to any concerns raised or suggestions made by people who used the service.

The provider did not conduct a formal staff survey. The registered manager told us this was because the staff group was very small. However, staff told us they could discuss any concerns or issues with the registered manager at any time.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving the service.

Requires Improvement

Diagnostic imaging

The service had invested in a digital system which allowed the service to conduct audits easily and identify trends for improvement. Staff had improved their knowledge around quality improvement and told us they planned to use the system as part of a quality improvement project.

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 **Regulation 17 Good governance** **2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to:** **a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);** **b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users** • The child scanning policy had been improved and made clear that interventional procedures were not carried out on children however the policy did not clearly state the age of children the provider was able to see. • Not all risks identified at the last inspection and this inspection were on the risk register.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 Safe care and treatment** **2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include:** **a) assessing the risks to the health and safety of service users of receiving the care or treatment;**

This section is primarily information for the provider

Requirement notices

b) doing all that is reasonably practicable to mitigate any such risks;

h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;

- The provider did not have a full anaphylaxis kit containing all of the required medicines
- The provider's medical trolley contained equipment that was not required for the type of procedures being carried out at the service. Some of the equipment was out of date and we also found a used glove in one of the drawers which meant that the contents of the drawer would have been contaminated.
- The sharps bin had not been signed and the lid had not been closed.