CHS UK Medical Ltd

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

Summary of findings

Overall summary

We have not previously rated this service. We rated it as requires improvement because:

- Staff did not always record risks to service users, act on them and keep good care records. The service did not always manage safety incidents well and in accordance with their policies. Staff did not always collect safety information and use it to improve the service.
- Leaders did not always run services well. Information and governance systems were not always reliable and did not support staff to develop their skills. Staff were not always clear about their roles and accountabilities which impacted on their commitment to improve services continually. Service policies needed to be reviewed to match the specific needs of the service.

However:

- The service had enough staff to care for service users and keep them safe. Staff had training in key skills, understood how to protect service users from abuse.
- Staff treated service users with compassion and kindness, respected their privacy and dignity, took account of their individual needs and helped them understand their treatment. They provided emotional support to service users, their families and loved ones.
- The service planned care to meet the needs of their customers. People could access the service when they needed it and did not have to wait for their results.
- Staff understood the services' vision and values and how to apply them in their work. The service was focused on the needs of the service users receiving care. The service engaged well with service users to plan and manage services

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Requires Improvement 	We rated this service as requires improvement overall because we rated safe and well led as requires improvement. We rated caring and responsive as good. We do not rate the effective domain in diagnostic and screening services. See the summary above for details.

Summary of findings

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Summary of this inspection

Background to CHS UK Medical Ltd

The service carries out diagnostic ultrasound scans for adults and children, both male and female, using their own dedicated ultrasound scanner. It also provides consultation and services for examination and treatment of musculoskeletal (MSK) disorders including ultrasound guided joint and tendon injections with reporting. In addition, the service also refer service users for MRI scanning to various centres. After receiving these scans the service reports them for diagnostic purposes, including advice on further management of their condition.

The service employs 2 consultants. One of the consultants was assigned as the service manager, registered manager and nominated individual.

The service has been registered with the CQC since November 2022 to undertake the regulated activities of treatment of disease, disorder or injury and diagnostic and screening procedures.

The service carried out 28 ultrasound scanning procedures between September 2022 and September 2023. It has also reported on 73 MRI scans within the same period.

We have not previously inspected this service.

How we carried out this inspection

Our inspection was unannounced. We inspected this service using our comprehensive inspection methodology.

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.

During the inspection we spoke with the service manager. On the day of the inspection there were no service users in clinic. Following the inspection, we contacted 3 service users to hear their experiences of care with the service.

Areas for improvement

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

Action the service MUST take to improve:

- The service MUST maintain accurate, complete and contemporaneous records in respect of each service user. (Regulation 17).
- The service MUST report all incidents in line with their incident reporting policy and report relevant incidents to the relevant external organisations. (Regulation 17).
- The service MUST strengthen their service auditing programme to account for service specific activity and identify potential areas of improvement. (Regulation 17).

Summary of this inspection

- The service MUST improve their governance processes to support the correct management of the services' activities, policies and risks and hold accountability of their actions against the established governance processes. (Regulation 17).

Action the service SHOULD take to improve:

- The service should ensure policies identify what version, updates and review dates have been used for each service policy. (Regulation 17).
- The service should record the use of the British Medical Ultrasound Society's (BMUS) 'paused and checked', checklist guidance with each service user's care record.
- The service should use standardised measurements and tools to ensure the ultrasound machine was quality assured and working well with relevant records of these processes.
- The service should ensure that peer reviews are dated and signed by their reviewers.
- The service should have clear visible information for service users on how to make a complaint.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic and screening services	Requires Improvement	Inspected but not rated	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Inspected but not rated	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Diagnostic and screening services

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

Is the service safe?

Requires Improvement

We had not inspected this service before. 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 received and kept up to date with their mandatory training.

The service had a mandatory training programme which was comprehensive and met the needs of service users and staff. Mandatory training requirements, including topics covered and frequency of training for each role were clearly identified in the mandatory training programme. Topics included: advance life support, infection prevention and control, risk management and mental capacity act.

The service manager monitored mandatory training and alerted staff when they needed to update their training. The service used an online training programme to deliver the mandatory training programme. The training programme had a training matrix showing when training was completed or due to be undertaken by each staff member.

Safeguarding

Staff understood how to protect service users from abuse and policies supported correct referral processes. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. The service manager who was assigned as safeguarding lead had received level three training in children and adult safeguarding and was identified as the service's key contact for safeguard queries. They told us that should they have any questions regarding safeguarding referrals they would contact the local authority safeguard team to clarify any points.

The rest of the team had been trained to at least safeguarding training level three for adults and children.

Requires Improvement

Diagnostic and screening services

Staff could give examples of how to protect people from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. Staff also told us how they would identify adults or children at risk or suffering from abuse and harm. Examples of this included identifying practices such as female genital mutilation.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had a safeguarding policy which supported the safeguarding referral pathway.

The service reported there were no safeguarding referrals or incidents in the last 12 months.

Cleanliness, infection control and hygiene

Staff used equipment and control measures to protect service users, themselves, and others from infection. They kept equipment and the premises visibly clean. However, the service did not complete regular audits to review their practices.

The service operated from a designated consultation room within another provider's facilities. The reception area and waiting room was spacious, clean, and welcoming. Sitting couches and seats in the reception area were made of easily washable material. We observed staff cleaning equipment and clinical areas during our visit.

The clinical area was visibly clean and had suitable furnishings which were clean and well-maintained.

Staff were bare below the elbow, and we were demonstrated by staff how they carried out correct hand washing techniques before and after interaction with service users. However, the service did not regularly audit cleanliness and infection control. The service identified that audits to infection prevention control (IPC) and hand hygiene should occur 4 times yearly and 2 times yearly respectively.

When we requested to view the audits for the period between September 2022 and September 2023, we were provided with 1 review for each module. In the hand hygiene audit tool we reviewed, there was only one episode of care observed in the last year which was dated 15 September 2023. The recorded assessment of the observed practice met the standards of the audit tool however, it did not assure us that regular oversight of practice was done through a rolling audit programme. In addition, the IPC audit focussed only on trans vaginal probe sterilization. This did not assure us the service monitored all infection control risks.

Staff understood IPC principles including the use of personal protective equipment (PPE). There were adequate supplies of PPE at the service such as masks and gloves.

Staff demonstrated knowledge of how to correctly clean and disinfect the ultrasound equipment. We saw record logs that ultrasound equipment was cleaned using the correct disinfectant to reduce the risk of cross infection. These logs were correctly labelled and used the right disinfection packs for vaginal ultrasound probes.

The service had not reported any incidents of a healthcare acquired infection in the past 12 months.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Requires Improvement

Diagnostic and screening services

The service had enough suitable equipment to provide a safe and caring environment for service users and their families. Staff reviewed and kept a log of their environment and equipment to ensure premises were safe.

The ultrasound machine was well maintained and cleaned. We reviewed the service records for the ultrasound machine which showed regular maintenance and servicing.

The service had suitable facilities to meet the needs of service users and their families. There was a reception area where staff greeted service users, which included a large waiting area with one couch and several single seats, a scanning suite, and access to a toilet. A disabled access toilet was also available as part of the communal building should this be required.

The scanning room was spacious and comfortably accommodated the consultant, service user and family members or chaperones should this be required.

Staff disposed of clinical waste safely. We observed staff disposing of clinical waste correctly in appropriate receptacles.

Fire extinguishers had been serviced in the last 12 months and there was a fire evacuation policy. This was done via a service level agreement with the owners of the building.

The service had a first aid kit at the premises which was easily accessible and had all items within expiry date. The service also had access to a blood and body fluid spill kit should this be required as well as access to a defibrillator which was kept in the premises of the building.

Assessing and responding to service user's risk

Staff received and undertook risk assessments for each service user. Staff knew what to do and acted quickly when there was an emergency. However, recording of risk assessments was inconsistent.

All service users completed a pre-scan questionnaire that included pregnancy history. The referral form used for this process included details such as name, date of birth and pregnancy status when relevant. The referral form also identified relevant service specific information such as the examination request and relevant clinical information.

Staff were able to articulate how they would respond promptly to any sudden deterioration in a service user's health. Both consultants were trained in basic life and advanced life support. Staff told us they would call 999 if a service user's condition deteriorated during their consultation.

The service had a policy and clear guidance for staff to follow if they identified any abnormality during the scan. Staff gave us examples of how they had informed service users of their concerns and findings and how they would make a referral to the relevant referrer or specialist and write a report to reflect their findings.

To safeguard people against experiencing incorrect ultrasound scans the service had a pathway that consisted of the clinician asking service users for their details and matching them with their bookings. This information was then used to confirm the service users' identity, date of birth and scanning procedure. However, we did not see any written evidence that the service was following the British Medical Ultrasound Society's (BMUS) 'Have you paused and checked?' safety guidance at the point of starting the scan.

The service manager reported they monitored any service users who requested frequent scans in short periods of time. They advised service users who wanted longer appointments that their scanning time was restricted as per BMUS guidance and followed the As Low As Reasonably Achievable (ALARA) principles, outlined in the 'guidelines for professional ultrasound practice 2017' by the Society and College of Radiographers (SCOR) and BMUS.

Staff shared key information to keep service users safe when handing over their care to others. The service user was provided with a report to take with them to the hospital or referrer or for further follow up appointments should this be needed. A copy of the report was also sent to the original referrer.

Staffing

The service had enough staff to keep service users safe from avoidable harm and to provide the right care. The service had the availability to access chaperones if required.

There was enough staff to cover the clinic's opening times with no current staff vacancies. The service employed two radiologist consultants. Both consultants were registered with the General Medical Council's specialist register for clinical radiology.

The service did not use bank or agency staff. If needed, appointments would be cancelled if any of the consultants were unavailable, and they were unable to fill the post. Clinics were planned around the consultants' availability.

The service could access trained chaperones from a regulated provider who also operated on the same site. This was part of a service level agreement between the 2 services to support the delivery of female care.

Records

Staff did not always keep detailed records of service user's care and diagnostic procedures. Records were not always clear, contemporaneous, and easily available to all staff.

Service user records were kept under the form of imaging reports. After each scan the consultant produced a written report of their findings from the scan. This was also the case for any diagnostic imaging reports produced.

Records were not always clear, contemporaneous, and easily available to all staff. The service held notes for service users, however these were not easily retrievable and in some cases not complete. The notes were stored in different folders and databases. Referrals were stored in the service's referrals email. Service user notes/ appointment records were stored on a secure database under the form of diagnostic reports. Paper records, such as consent forms, were not uploaded to a joint service user folder but stored separately in the relationship managers' reporting office.

During the inspection we also requested and were told there was no recorded evidence of follow up appointments to review imaging findings. Additionally, we found 2 records where additional screening procedures were requested but these were not documented. It was also reported that verbal consent was not always recorded in the service users notes. This went against the provider's own consent policy.

The service did not regularly audit their notes in line with their auditing schedule. The service's auditing schedule identified that service user records and consent forms should be audited 4 times yearly. When we requested the audits for the period between September 2022 and September 2023 we were provided with just one audit which was dated 25 September 2023. This was undertaken after our inspection date. We were not assured the audit was run effectively as

findings were not reflective or in line with of our findings on the day of the inspection. As an example, of the 15 service user records reviewed there were no concerns raised and there was no mention on how the service had progressed from several databases to store service user information to a single record for each service user. Additionally, the audit did not address how documentation of verbal consent was going to be recorded.

The ultrasound machine was in a clinical room that was part of another locations clinical area. The room had sometimes been used to support clinical care from that provider when the service was not operating. On the day of the inspection, it was noted that the ultrasound machine was not password protected. We informed this to the service manager who contacted the ultrasound machine servicing team to install a password protection on the device. We have received evidence this issue has been addressed.

Images from scans were transferred to a memory stick, uploaded to a computer and could be uploaded and shared via secure email with service user's and referrers. Access to each scan's images was password protected including when these were shared and transferred to the service user.

Incidents

Staff did not always recognise and report incidents and near misses.

Staff knew what incidents to report and described how to report them. The service had an incident reporting policy which contained in it an incident reporting form. The policy outlined that any raised incident was investigated by the service manager. Staff were able to articulate how they would raise concerns or report an incident or near miss in line with the service's policy.

However, we were not assured that all incidents were effectively reported by the service. The service stated that no reportable incidents, near misses or any form of incidents had occurred between September 2022 and September 2023. However, during the inspection we found 3 occurrences which were potential incidents. As an example, we found that the high-level disinfectant trio wipes used for transvaginal probes had expired their use by date in August 2023. No ultrasound screenings had been performed since then. We highlighted this to the service and queried if this would be considered an incident or near miss in accordance with the service incident reporting policy. The service manager reported that it should be identified as a near miss as the service was unaware that the expiry date had elapsed and there was a risk the trio wipes could be used.

Additionally, we found service user data (images and service user identifiable information such as name and date of birth) that was not relevant and did not belong to the service stored within in the ultrasound scanning machine. This information was dated before the service's registration date. We highlighted our concerns to the service and requested they took the appropriate action in line with their policies. We received assurances on the day of the inspection that the service would do this. As part of the inspection process, we requested the service's incident reporting document and received the record of the 3 potential incidents we highlighted during the inspection. However, these were not recorded in line with the service's incident reporting policy. For example none of the incidents had been graded and the findings of the data breach where not reported to the relevant authority.

The service had made no notifications to external bodies/agencies in the past year. This did not meet the required standards of reporting for the incident relating to the service user data we found that was not relevant to the service, nor did it follow the services incident reporting policy.

Requires Improvement

Diagnostic and screening services

Staff understood the duty of candour. They were able to articulate how to be open and transparent and told us how they would give service users and families a full explanation if things went wrong. However, we saw no evidence that this was being followed or considered in any of the reported incidents since our inspection.

Is the service effective?

Inspected but not rated

We have not previously rated this service. We inspected but do not rate this domain in diagnostic and screening service inspections.

Evidence-based care and treatment

The service provided care and procedures based on national guidance and evidence-based practice. However, the service did not comply with its own audit schedule. There was no evidence of a comprehensive service level audit or assurance programme to monitor compliance with care and treatment policies.

Staff followed policies to plan and deliver quality care according to best practice and national guidance. We reviewed 13 service policies. Policies had been produced using national guidance. However, not all policies were dated, had clear review dates or an author and responsible person. We were told by the service manager that updates to policies and procedures were done through regular review meetings however this was difficult to monitor as the policies did not identify different versions and review meeting minutes were not always clear on what policies had been discussed.

Staff followed guidance and recommendations from the British Medical Ultrasound Society (BMUS), As Low As Reasonably Achievable (ALARA) principle, they used the lowest possible output power while also keeping scan times as short as possible which still allowed to gain correct and required results.

The service had established an audit schedule to support the delivery of the service. This included audits such as service user records and consent forms, treatment outcomes and infection control. However, the service did not comply with its own audit schedule. There was no comprehensive service level audit or assurance programme and records of these were not complete. We requested to see the audits and there was no evidence of the audits being undertaken regularly. Additionally, some audits were merged with other service activities, for example outcomes were reviewed as part of peer reviews, but the findings and outcomes were not audited and documented as an audit.

As part of the inspection process and during the additional data request stage we requested the audits for service user records and consent forms, infection control and hand hygiene carried out in the year prior to our inspection. The service only provided one audit in the last year for service user records which was carried out after our inspection date. The findings in the audit did not match the findings of our inspection but reflected the changes put into the service after our inspection. Additionally, the audit did not provide assurances of follow up actions, the owner of those actions and how the service would improve the quality of services provided.

The infection control audit was carried out on 15 September 2023 and only one audit was presented when policy identified this should occur 4 times a year. Additionally, the audit only monitored transvaginal probe sterilisation and

did not monitor other infection risks. With regards to hand hygiene the audit should be carried out twice yearly. We received one audit dated 15 September 2023; it was unclear how many episodes of care had been monitored. These findings indicate that the service did not have established mechanisms to regularly check the safety and quality of the service and improvement initiatives carried out by the service.

Patient outcomes

Staff monitored the quality of care regarding service user satisfaction. However, we did not see evidence they used quality assurance findings to make improvements and achieve better outcomes for service users as these were done subjectively and not recorded.

The service monitored outcomes for service users and their experience through peer reviews and client satisfaction feedback and complaints. Positive feedback from service users indicated that almost all service users had a positive experience.

The service manager carried out randomised subjective image quality checks to assure the quality of the service. This included the type of scan performed, a subjective review on the quality of the scan and any challenges that could impact the quality of the scan. However, the service did not use standardised measurements and tools to ensure the ultrasound machine was quality assured and working well between servicing periods. No records of quality assurance completed by staff were done.

Competent staff

The service made sure staff were competent for their roles. However, peer reviews were not dated and signed by their reviewers.

Staff were qualified and had the right skills and knowledge to meet the needs of service users. Both consultants were registered with the General Medical Council's specialist register for clinical radiology.

All staff, who were eligible, had received an annual appraisal and peer review. We reviewed 1 of the staff's peer reviews and found that a peer review was carried out for 35 scanning procedures between December 2020 and April 2023. The peer review did not have any review date identifying when the review was carried out and there was no named person of who had carried out the review. We raised this with the service manager who said that as there were only 2 members of staff they reviewed each other. The peer review did not identify any areas for concern, learning points or action points. It also didn't state when the next peer review would be required.

Multidisciplinary working

Staff worked together as a team to the of benefit service users. They supported each other to provide good care. However, records of follow up meetings where not taken which did not ensure information passed on to service users was documented and could be shared with other health professionals.

Staff held regular meetings to discuss service users experience and improve their care. We reviewed meeting records and saw these points were discussed between both clinicians.

Requires Improvement

Diagnostic and screening services

Staff understood clinical pathways and how to liaise effectively across health care disciplines and with other agencies when required, to support and care for the service users. The service had a referral process to record any referrals completed and the reason for the referral. These were documented in the service users' imaging reports. However, records of follow up meetings with service users where not recorded which meant information passed on to service users was not documented and could not be shared with other health professionals efficiently.

The service had a policy for non-medical referrals which ensured that any referrals that were made from non-medical practitioners and that required consultant sign off were reviewed and appraised before being accepted and carried out. This ensured that service users did not undertake unnecessary scans or be exposed to unnecessary imaging risks.

The service offered chaperone service to all service users who required their presence.

Seven-day services

Services were available to support timely care.

At the time of our inspection the service provided ultrasound scans dependant on service users' feedback and needs. The service ensured that service users were seen soon after their referrals or self-referrals and that reporting was done in a timely and responsive way, with follow up appointments booked on the basis of the findings.

Health promotion

Staff would offer practical support and advice to lead healthier lives if this was requested.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported service users to make informed decisions about their care. They knew how to support service users who lacked capacity to make their own decisions or were experiencing mental ill health. They followed national guidance to gain consent however, recording of consent was not always completed.

Staff received and kept up to date with training in the Mental Capacity Act. Staff were able to articulate how they accessed the Mental Capacity Act policy and the processes outlined within to gain consent and assess capacity if they needed to.

Staff gained consent from service users for their care and treatment. However, as referred in the safe section of this report, recording of consent was not always documented.

Is the service caring?

Good

We have not previously rated this service. We rated it as good.

Compassionate care

Requires Improvement

Diagnostic and screening services

Staff treated service users with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Service users told us staff understood and respected the personal, cultural, social and religious needs.

We heard from service users that staff interacted with them and their partners in a kind and caring way. Feedback forms provided to the service and email feedback showed that staff treated them in a kind and respectful way.

Staff were discreet and responsive when providing care. Service users told us staff took time to speak with them and those close to them in a considerate way.

Service users said staff treated them well and with kindness. We reviewed 5 feedback forms completed by service users after their scan or reports and everyone gave a high score for all areas covered in the form. Additionally, all feedback forms gave the highest score when asked if they were treated with privacy, dignity and respect.

We spoke with 3 service users and their partners, and they described the care they had as being very good and said they felt reassured by the services provided.

There was an ethos of staff to support service users' cultural, religious and social needs. We saw examples where people commented on staff accommodating out of work hours appointments to give service users more flexibility towards their work life balance.

Emotional support

Staff provided emotional support to service users, families and carers to minimise their distress. Staff knew how to give service users and those close to them help, emotional support and advice when they needed it.

Service users feedback demonstrated how staff explained the ultrasound procedures and ensured service users were well informed and knew what to expect. Service users told us they could pause the procedure at any time and that staff assured them if they were concerned.

Staff were able to talk us through the procedure when abnormal results or concerns were detected. The consultant would first monitor the scan on their screen to ensure all was well before sharing any findings. The consultant would then inform the service user what they had seen and that they needed to do a referral either to an NHS service that could support them or to a service that was of the service user's preference.

Understanding and involvement of service users and those close to them

Staff supported service users, families and carers to understand their scan and make decisions about their care and treatment. Staff made sure service users and those close to them understood their care and procedures.

Staff talked with service users, families and carers in a way they could understand. We were told by service users, staff talked through the scan about relevant findings and guided them through the images from the scan with a language that was easy to understand. Service users also praised staff by saying any questions were answered quickly and confidently.

Requires Improvement

Diagnostic and screening services

Service users and their families could give feedback on the service and their treatment and staff supported them to do this. The feedback form was comprehensive and covered key areas such as pre consultation and preparation information, time to ask questions, usefulness of the information provided and whether the service user would recommend the service to their family. We reviewed 5 feedback forms and all of them rated the service as excellent and said they would recommend the service to their families.

All service users we spoke with were clear in what treatment they were having and the associated costs. These were clearly displayed on the service's website and discussed prior to any scanning and reporting procedures.

Is the service responsive?

Good

We had not inspected this service before. We rated it as good.

Service delivery to meet the needs of local people

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

The service offered a range of ultrasound scan screening procedures for private fee-paying adults and children. They also offered reporting services for MRI scans. The service could also offer pain management and guided injections as well as other reporting modalities for diagnostic imaging.

The service planned and organised services, so they met the changing needs of service users. Clinic opening times meant that those people who were working could book an appointment in the evening or over the weekend, and there was flexibility to accommodate people's individual needs.

The facilities and premises were appropriate for the services being delivered. The service had a suitable environment for providing ultrasound scanning procedures and a safe environment to discuss imaging findings and report outcomes of diagnostic imaging procedures.

There was enough capacity in the waiting area to allow for social distancing and privacy. The scanning room was spacious and provided a suitable and relaxed environment to undergo ultrasound scan procedures whilst maintaining privacy and dignity.

The premises were easily accessible for service users including those with limited mobility.

Appointments were booked in advance, online or by telephone, and this allowed staff to plan the scanning procedures or consultation services before service users attended their appointment.

Meeting people's individual needs

Requires Improvement

Diagnostic and screening services

The service was inclusive and took account of service user's individual needs and preferences. Staff made reasonable adjustments to help service users access services. They directed them to other services where necessary.

The service ensured there were separate sessions for all service users who accessed the service. This ensured they felt more at ease during their appointment and should a scan not produce the desired images or concerns needed to be raised there was time and a safe space to do so.

Staff had received equality and diversity training as part of their role and understood their role in supporting the individual needs and protected rights of service users.

The service used an online translation service to communicate with service users and their families whose first language they were not familiar with. This ensured that any relevant information such as safety questions and explaining the scanning process was translated to the service users' language and completed jointly with the staff.

The service was accessible for persons with limited mobility. Although the scanning room was located on the first floor of the building which only had stair access, the service had an agreement with the premises in which they could use a room located on the ground floor to undergo any scanning procedures for people with limited mobility or who required support for mobility transfers.

All scans and procedures and their prices were clearly displayed on the service's website. There was information for prospective clients about what to do before arriving at the clinic, what would happen on arrival and the scan itself. There were also frequently asked questions on the website. Service users could also telephone or email for additional information.

Access and flow

People could access the service when they needed it. They received the right care and their results promptly. Managers monitored and took action to minimise missed appointments.

All service users attending the service were private service users. Service users could book their appointments in advance and at a time and date of their choice. Appointment bookings were made in person, by telephone or directly through the provider's website.

Service users were given appointments based on their preference. There was no waiting list for appointments, and appointment availability was offered promptly (including the same day in some instances). Service users who had to cancel their appointments were given an alternative date and time.

The service manager took action to minimise missed appointments. Service users were routinely given a protected appointment time slot depending on their scan or appointment, but this could be extended if needed. If someone missed their appointment the service would contact them to assure that all was well and rebook the appointment at a convenient date.

Staff supported service users when they were referred to other services. Staff explained how referrals, reports and abnormal findings were shared immediately with service users and other health professionals to promote immediate action and care.

Requires Improvement

Diagnostic and screening services

Learning from complaints and concerns

The service had processes in place to treat concerns and complaints seriously, investigate them and share lessons learned with all staff. People could give feedback and raise concerns about care received.

The service had received no formal complaints in the 12 months before our inspection.

The service had a complaints policy in place to support the management of complaints. Staff understood the policy on complaints and knew how to handle them. They told us that if a complaint had been raised, they would always try to deal with it at the point of care. If someone wanted to make a formal complaint, this could be made in writing to the service's manager and staff would support the service user in doing so. An acknowledgement of the complaint would be given and a resolution to the complaint found in agreement with the complainant.

Complaints could be raised in the main reception area or with the clinician in the consulting room. The point of raising complaints in the reception area was shared with the other service provided at the premises. If concerns about the service were raised these would be highlighted immediately to the service manager.

The service had an online "contact us" and "reviews" form which was regularly checked by managers to pick up any complaints. Service users, relatives and carers we spoke with knew how to complain or raise concerns and said they would do so directly at the point of contact or via the online "contact us" form. However, it was highlighted during the inspection that the information relating to raising a concern with the service should be visibly displayed on site in the reception area or in the clinical room so that all people knew how to raise a concern and the procedures to follow.

Is the service well-led?

Requires Improvement

We have not previously rated this service. We rated it as requires improvement.

Leadership

Leaders did not always understand their regulatory duties to the service. However, they understood and addressed the clinical priorities and issues the service faced. They were visible and approachable in the service for service users.

The service had the same registered manager in place since it first registered with the CQC in November 2022.

We heard how the manager had a clear list of priorities and action points to address the needs and sustainability of the service.

The service manager did not always understand the duties and responsibilities associated with their role as registered manager and nominated individual. As an example, the service manager did not ensure compliance with the regulations was monitored effectively and did not have an intrinsic knowledge of regulations and essential regulation standards.

Requires Improvement

Diagnostic and screening services

Service users said they felt comfortable liaising with staff.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on quality and sustainability of services. Leaders and staff understood these however, there was no clear plan to monitor progress.

Managers told us that they wanted to provide service users with a safe, caring, and comfortable service. They wanted to deliver ultrasound technology to all customers in a professional manner and that they wanted to promote excellence and ensure accuracy in all areas of scanning and reporting.

The vision and strategy of the service was shared between both members of staff. It was important to ensure that every service user's experience was the best the service could provide.

There was a plan for the service manager to deliver the service against this vision. However, we did not see evidence of continuous and regular use of objective measuring tools to promote good services and learning for the future. Despite the service reviewing service users' feedback to measure the success of their services they did not use other outcome measures such as their audit programme to support the delivery of their strategy. They also did not have referential outcomes and objectives to ensure the delivery of their programme met their targets.

Culture

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

The service manager was motivated and positive about their clinical work. They told us and described the culture of the service as being friendly, client focused and open. They focused highly on the delivery of their clinical work and the satisfaction of their clients and regularly reviewed feedback from service users.

The service manager stated both he and the other consultant worked well as a team. Any issues or concerns were discussed and managed well. As a small team it was important this happened to ensure the best service possible

The service manager told us that they enjoyed working in the service and looked forward to having the service grow.

Governance

Leaders didn't always operate effective governance processes, throughout the service. Staff were clear about their clinical roles and accountabilities but not of their governance responsibilities.

The service had policies and procedures for the operation of the service however, not all policies were easily available as they were stored on the service manager's computer and filing system with several copies of the same policy replicated or duplicated. Of the 13 policies we reviewed on the day of inspection 9 lacked a clear date of review, did not have a planned review date or did not identify who was the author and responsible person for the policy. Some policies also needed to be reviewed to match the specific needs of the service as they contained policies and procedures that were not relevant to the service.

We highlighted our concerns to the service manager during the day of the inspection and requested some policies through the additional data request stage of our inspection to assess if the issues identified had been addressed as the service manager assured us this would be the case. Although some policies addressed concerns such as review and review by dates, others didn't and therefore we were not fully assured all elements of our findings had been integrated into the policies we requested.

The service manager had overall responsibility for clinical governance and quality monitoring. This included investigating incidents and responding to complaints. We saw that the responsibility of these processes were assigned to one individual. As we have reported in the safe section of this report we were not assured that incidents were well managed and reported in a timely manner.

We were informed on the day of inspection that the service had a directors meeting every 6 months and on an ad hoc basis should an issues or concerns be raised. We requested the minutes of the last 3 meetings and were provided with 2 meeting minutes for September 2023 and 1 meeting minutes for February 2023. This did not assure us that the ad hoc meetings were being recorded and minuted accurately.

We reviewed the records for the directors meeting minutes provided and saw that they included agenda items such as complaints, MHRA notifications and learning from incidents. The minutes of the meetings were not set as a set agenda for each meeting. We also did not see any actions from the meetings in relation to the services findings. As an example, in the meeting held on 15 September 2023 an item on the agenda was the review of the service user's record and filling audit. There were no minutes identifying if this had been presented or discussed or if action was going to be taken in relation to any findings. Additionally, actions were not dated and did not have an assigned owner of the action.

The service had an audit programme which included audits and quality review audits. As discussed in the effective key line of enquiry of this report we were not assured the service had a comprehensive service level audit or assurance programme to monitor compliance with care and treatment policies.

The service had a fit and proper persons policy that all staff were required to comply with. We saw evidence that both staff members underwent recruitment checks, such as enhanced disclosure and barring service (DBS) checks and review of their GMC status.

Management of risk, issues and performance

Leaders did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identified actions to reduce their impact in a timely manner. However, the service had plans to cope with unexpected events.

The service held a centralised risk record that did not fully reflect the services' risks. During the inspection when we asked what the main risks of the service were we were told the 3 main risks to the service were infection prevention control, emergency findings and complaints. We were also informed that the register was reviewed every 6 months for accuracy and updates. When requesting the most up to date risk register, we were provided with a risk register that did not contain any of the 3 key risks identified and that was last reviewed in November 2022. This did not follow the risk management process identified by the service manager. When asked how the service monitored what issues could become a risk they said that issues or concerns were monitored and managed through the directors meeting or through ad hoc team meetings. We requested the 3 most recent minutes of these meetings and did not see evidence of how risks were being discussed and raised with actions against them into the service's risk register.

Requires Improvement

Diagnostic and screening services

We saw risk assessments were completed in relation to the service. We reviewed the risk assessments for fire, health and safety, general data protection and the ultrasound scanner. Risk assessments identified, the risk and control measures and the member of staff responsible for monitoring and managing the risk. The risk assessments had all been carried within the last 12 months and had the risk review date present.

The service had appropriate emergency action plans in place in event of incidents such as power loss or fire. These outlined clear actions staff were to take and contact details of relevant individuals or services.

Information Management

The service did not collect reliable data. Information was scattered and sometimes repeated in several version of the same documents. Service user records were not easily accessible and were stored in different information systems. The information systems were not integrated but were secure.

We reported our findings on service user records and our concerns regarding the access and use of information under the records section. We highlighted our concerns to the service on the day of the inspection and were assured that the service would be addressing our findings. We received assurance in form of a statement that the service will ensure "All the service users records i.e. referral forms, reports, clinical notes of any discussions …etc are kept in one file under the service user name. This makes it easily accessible. The patients' files are stored on the computer which has a log in password". We also requested to see the updated policy for service user storage and filling and relevant assurance systems through the additional data request stage of the inspection but did not receive this or any further update.

Staff received training for information governance and the general data protection regulation.

Computer terminals were password protected. The scanning machine was in the process of being password protected at the time of this report in line with what was described in the safe section of this report.

The sharing of images had a unique access code for each service user to access their images.

Engagement

Leaders actively and openly engaged with stakeholders, partner organisations, service users and staff.

Staff engaged with other health care disciplines and with other agencies when required to support the care for service users. This engagement was mainly done when there were reasons of concern or to ensure referrals were completed accurately and reports shared in a timely way.

The service engaged with the provider who was responsible for the physical environment and who held a service level agreement for the management of cleaning, waste management and ensuring the safe management of the physical environment.

Staff routinely engaged with service users during their scan procedures to gain feedback about the services. The service manager told us client feedback was regularly reviewed.

The service was mainly promoted through their website and through word of mouth from service users that had used the service. Staff engagement took place through daily communication and routine meetings.

Requires Improvement

Diagnostic and screening services

Service users said they had enough information before coming to the clinic and that appointments had been easy to book.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

There was a culture of continuous clinical learning and innovation. As an example, the service was introducing a new screening system that supported both the psychological and physical wellbeing of service users aged 40 and above. This included a complete set of diagnostic scanning procedures and blood tests that looked to identify potential red flags for early onset of several chronic conditions.

The service was committed to maintain their earning and update their standards of clinical practice. We were told clinicians regularly attended study and development days as well as conferences. They also maintained key contacts with relevant specialists in clinical areas to identify any new trends and procedures, so they kept up to date with current practice.

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 • The service did not always maintain accurate, complete and contemporaneous records in respect of each service user. • We were not assured the service reported all incidents in line with their incident reporting policy and that they reported incidents to the relevant external organisations. • The service's auditing programme did not account for service specific activity and we did not see evidence of the auditing process identifying potential areas of improvement. • The service's governance processes was unable to support the correct management of the services' activities, policies and risks and hold accountability of their actions against the established governance processes.