West London Diagnostic Limited

West London Diagnostic Limited

Inspection report

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

Ratings

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

Summary of findings

Overall summary

We rated the provider as inadequate because:

- We found that the ultrasound machine had not been serviced and PAT tested.
- The service did not control infection risk well. We found that there was no cleaning log for the clinic room, chairs, examination couch and ultrasound machine which was visibly dirty. Although staff changed their gloves between patients, they did not wash their hands between patients.
- We found a sharps bin which was full and had not been dated or signed which did not follow NICE guidance around the safe use and disposal of sharps.
- The service had not actioned the National Patient Safety alert in relation to the safe use of ultrasound gel to reduce infection risk and was decanting ultrasound gel into bottles which had old dates on them. This was an infection control risk.
- The service did not have its own medicines management policy with detail around the medicines and procedures specifically related to the provider.
- Medicines were stored in a locked cupboard in a room accessed by staff only however the temperature of the room where the medicines were stored was not being monitored or logged.
- We found that the contents of the anaphylaxis kit were in date however there was no log of checks for the kit to make sure everything was in date and nothing was missing.
- The service did not keep formal governance meeting minutes containing detailed discussion and actions.
- The service's policy for the scanning of children did not make clear that the service did not undertake interventional procedures for children.
- The service's complaints policy incorrectly stated that complaints can be referred to CQC for independent review.
- The service did not have a deteriorating patient policy.
- The provider did not ensure work was in line with evidence-based practice. The service did not have written clinical protocols and policies in place.
- The service did not have effective audits in place to measure the effectiveness of the service that they provided. The service did not undertake quality assurance for the ultrasound machine.
- The service did not have a comprehensive audit programme.
- The service's safeguarding policy referred to out of date versions of national guidance and did not contain details on how staff can make a safeguarding referral.
- The service did not have a comprehensive risk register outlining the risks to the service specifically.
- The registered manager was not clear on the requirements of a practising privileges policy and did not ensure that the service followed its practising privileges policy.
- We found that some of the provider's policies were missing, did not contain up to date guidance, reflected incorrect information, or was not sufficiently detailed.

However:

- Patient feedback we reviewed and patients we spoke with were positive about the care and service they had received.
- Staff we spoke with spoke highly of the manager.
- Patient records were comprehensive and clear.
- Staff treated patients with compassion and kindness, and took account of their individual needs

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. This notice of urgent suspension of their registration was given because we believe that a person will or may be exposed to the risk of harm if we do not take this action. Details of our findings and the evidence supporting our ratings are set out in our report.

I am placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Victoria Vallance

Director of Secondary and Specialist Healthcare

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Inadequate 	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 to children. The service is located in Ealing in West London. 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 and patients using health insurance who are mainly from West London, with a few patients from outside London.

Summary of findings

Contents

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 to children.

The service is located in Ealing in West London. 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 and patients using health insurance 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 9 September 2022 and undertook telephone interviews on 14 September 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, consultant, the healthcare assistant, the administrative staff member, and three patients.

We reviewed eight patient records and observed ultrasound scan procedures with patients' consent and spoke to patients about their experience of the service. We also reviewed feedback from previous service users.

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.

Summary of this inspection

Action the service MUST take to improve:

- The service must ensure that the ultrasound machine is regularly serviced and PAT tested.
- The service must ensure there is a cleaning log for the ultrasound machine, clinic room, chairs and examination couch.
- The service must ensure that sharps bins are dated and signed when full.
- The service must action the National Patient Safety alert in relation to the safe use of ultrasound gel to reduce infection risk.
- The service must have its own medicines management policy with detail around the medicines and procedures specifically related to the provider.
- The service must ensure the temperature of the room where medicines are stored is monitored and logged.
- The service must ensure the contents of the anaphylaxis kit are logged and checked regularly.
- The service must keep formal governance meeting minutes containing detailed discussion and actions.
- The service's policy for the scanning of children must make clear that the service does not undertake interventional procedures for children.
- The service must amend the complaints policy to ensure that the CQC's remit is not misrepresented.
- The service must ensure there is a deteriorating patient policy.
- The service must undertake quality assurance for the ultrasound machine.
- The service must have a comprehensive audit programme.
- The service must have clinical protocols and policies in place.
- The service must ensure that the safeguarding policy refers to up to date versions of national guidance and contains details on how staff can make a safeguarding referral.
- The service must have a comprehensive risk register outlining the risks to the service specifically.
- The registered manager must be clear on the requirements of a practising privileges policy and must ensure that the service follows its practising privileges policy.

Action the service SHOULD take to improve:

- The service should ensure that a screen is used for patients 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	Inadequate	Inspected but not rated	Good	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Inspected but not rated	Good	Requires Improvement	Inadequate	Inadequate

Inadequate

Diagnostic imaging

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

Are Diagnostic imaging safe?

Inadequate

We rated safe as inadequate.

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.

Modules included but were not limited to safeguarding, 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. Modules were a mixture of 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. However, the safeguarding policy did not reference up to date versions of national guidance and did not contain instructions on who staff should 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 children and adult safeguarding. Staff we spoke with knew how to identify adults and children at risk of, or suffering, harm.

However, when we reviewed the safeguarding policy we found that it referred to an out of date version of the Working Together to Safeguard Children national guidance from 2010. We also found that the safeguarding policy did not include contact details or instructions on how to report safeguarding concerns.

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

Inadequate

Diagnostic imaging

Cleanliness, infection control and hygiene

The service did not control infection risk well. We found that there was no cleaning log for the ultrasound machine, clinic room, chairs and examination couch.

We found that there was no cleaning log for the ultrasound machine to indicate when it had last been cleaned. During our inspection we saw that the ultrasound machine had visible traces of gel, ink from a pen and dust.

We found that there was no cleaning log for the clinic room, chairs or examination couch. This was an infection control risk and may expose service users to the risk of harm as it was not possible to know when the room and equipment had last been cleaned. The service told us a domestic cleaner was employed to clean the clinic rooms, toilet and waiting areas but we did not see cleaning logs for these.

During our 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 was a risk of cross contamination. There was also an infection control risk from the gel to the probe due to gel being decanted into the bottle.

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

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. However, during our inspection, we observed that although staff used gloves and used new gloves for each patient, they did not wash their hands after each patient. The UK Health Security Agency guidance for the Safe use of ultrasound gel states that for both sterile and non-sterile gel, healthcare workers must carry out hand hygiene before and after the use of ultrasound gel.

The service did audit hand hygiene on a monthly basis. We reviewed the most recent hand hygiene audit for August 2022 which 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. However, there was no oversight of the equipment used for reporting and the ultrasound machine had not been serviced and had not had a portable appliance test.

The service had access to enough suitable equipment for diagnostic purposes. However, staff did not log or carry out safety checks of specialist equipment. During our inspection we found that the ultrasound machine had not been serviced. A sticker on the machine indicated a next service date of July 2021 however this had not been completed. Ultrasound machines must be serviced regularly to ensure they are functioning correctly to ensure service user safety as per British Medical Ultrasound Society guidelines.

We also found that the ultrasound machine had not had a portable appliance test (PAT). Electrical equipment should be examined regularly to ensure they are safe to use. This is a potential risk to service users as the ultrasound machine had not been checked for electrical defects.

The service did not undertake quality assurance for the ultrasound machine. This meant that the service was not ensuring that consistent, reliable results were being recorded and were not checking for deterioration of equipment performance which could negatively impact on service user safety.

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. This meant that if bins were handled when completely full, needles could cause harm to the person moving or disposing of the waste.

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. However, the service did not have a deteriorating patient policy.

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 however 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.

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 dependent on the findings, patients would need to go to the local accident and emergency department. During our inspection we asked to see the unexpected findings pathway but the provider was not able to produce one. Following the inspection, the service sent through an unexpected findings pathway which detailed what staff should do if there was an unexpected finding on a scan.

Following the inspection, the service submitted their policy on the scanning of children. However, the policy did not make clear that the service did not undertake interventional procedures for children.

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.

Inadequate

Diagnostic imaging

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.

The service did not used 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.

We reviewed eight sets of records and saw that they were fully completed. 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.

Patients were given an information leaflet which contained a summary of the procedure undertaken and patients seen for musculoskeletal pathways were 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.

Medicines

The service did not have systems and processes in place to safely store medicines and did not have a medicines management policy which was specific to the clinic's activities.

During our inspection we found that there was no medicines management policy specific to the clinic's activities. We were shown a general medicines management policy for both the physiotherapy clinic and the provider however there was no specific information for the provider's staff around the recording, handling, storage and security, dispensing, safe administration and disposal of the medicines held at the clinic. This was a risk as staff could follow different processes which could impact on patient safety.

We found that medicines were stored in a locked cupboard in a room accessed by staff only however the temperature of the room where the medicines were stored was not being monitored or logged. The medicines as well as the anaphylaxis kit need to be kept in a room no warmer than 25 degrees Celsius. The room was very small and windowless and could get very warm but there was no way of checking if the room temperature exceeded this temperature. This was a risk to patients because the efficacy of medicines may be impacted if the temperature in the room fluctuated.

We found that the contents of the anaphylaxis kit were in date however there was no log of checks for the kit to make sure everything was in date and nothing was missing.

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

Inadequate

Diagnostic imaging

Medicines used in patients' procedures were clearly listed in patient records. We saw in patient records that allergies were clearly documented. 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.

Are Diagnostic imaging effective?

Inspected but not rated

We do not rate effective for diagnostic services.

Evidence-based care and treatment

The service did not provide evidence of policies using national guidance and evidence-based practice.

There were no clinical policies or written protocols relating to the scans undertaken at the clinic. Therefore, we could not be assured that scan reports adhered to national guidance or were in line with evidence-based practice.

The provider did not have an audit schedule in place to audit their work against guidelines from the National Institute for Health and Care Excellence (NICE) or British Medical Ultrasound Society guidelines. Consultant radiologists did not receive peer reviews to ensure their work was evaluated.

The service audited patient feedback and hand hygiene but did not conduct other audits such as WHO checklist, infection prevention and control and scan reports. This meant that the provider was not able to ensure effectiveness of the service as they were not monitoring areas to identify improvements.

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. There are three levels of QA: 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 was not ensuring that consistent, reliable results were provided by the machine and were not monitoring deterioration of equipment performance which could negatively impact on patient safety.

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.

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.

Patient outcomes

Staff did not monitor the effectiveness of their service.

The service did not carry out a comprehensive programme of repeated audits to check improvement over time. This meant we were not assured that outcomes for patients were positive, consistent and met expectations such as national standards.

The service was able to demonstrate that it participated in the national clinical audit for patient reported outcome measures (PROMS). However, it was not clear if outcome data was reviewed or discussed with the clinic team and if learning was shared.

We reviewed patient feedback received in the last 12 months, all of which were positive.

There was no 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.

Competent staff

The service made sure staff were competent for their roles. The registered manager did not hold supervision meetings with staff to provide support and development.

The service employed an administrative member of staff who managed bookings, a healthcare assistant who also acted as a chaperone and two consultants (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.

Consultant 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 held immediate life support training.

However, 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.

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

The registered manager did not hold formal staff meetings. During the inspection, the provider was unable to show us team meeting minutes and when we spoke to staff, they told us they did not have formal staff meetings on a regular basis where updates were be shared or learning needs identified. Following the inspection, the service submitted team meeting minutes however they did not contain detailed discussion and actions.

Inadequate

Diagnostic imaging

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.

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.

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?

Good

We rated caring as good.

Inadequate

Diagnostic imaging

Compassionate care

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

Staff were discreet and responsive when caring for patients. We observed staff taking the time to interact with patients in a respectful and considerate way.

Patients we spoke with told us staff treated them well and with kindness.

We saw that staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. There was always a chaperone during a procedure. We observed this on the day of our inspection and patients we spoke with also confirmed this.

Patient feedback was positive. Comments included: 'friendly service'; great care, happy with treatment'; 'very professional'; 'speedy appointment'; 'very helpful'.

However, there was no screen available in the clinic room for patients to get changed behind to maintain their privacy and dignity.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff explaining the procedure in detail throughout the examination and showing scan pictures to ensure the patient understood what was happening and to allay any anxieties they had.

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. Patients we spoke with told us staff were very reassuring and supportive throughout the examination.

Staff were aware of patients' anxieties and we observed staff putting patients at ease by spending extra time explaining a procedure to them and answering questions the patient had.

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 talked with patients, families and carers in a way they could understand. Staff supported patients to make informed decisions about their care. We observed staff explaining the procedure to patients and taking the time to answer questions before going ahead with the procedure. We observed the consultant explaining where the scan report would go and the medical pathway going forward. Patients we spoke with told us the consultant explained the patient pathway clearly, that they were asked to fill in a safety questionnaire and consent form prior to the appointment and felt fully informed and prepared for the appointment.

Inadequate

Diagnostic imaging

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw that patients gave positive feedback about the service. An online patient feedback questionnaire was sent to patients after their appointment.

Patients we spoke with told us that they felt comfortable asking questions. We observed patients being given transparent and accurate information about all the costs involved for the procedure and patients we spoke to told us everything was explained to them clearly before the appointment. They told us prices were also clear on the service's website.

Are Diagnostic imaging responsive?

Requires Improvement

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.

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. The service told us that they met their key performance indicator for the turnaround of reports 100% of the time.

Meeting people's individual needs

Staff made reasonable adjustments to help patients access services however the building that the clinic was located in was not wheelchair friendly.

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

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.

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.

The service did have access to an external interpreter service which was available to patients whose first language was not English. However, patient information leaflets and patient questionnaire papers were available only in English.

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

Inadequate

Diagnostic imaging

Access and flow

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

Patients we spoke with told us they were able to book an appointment easily and be seen without delay. A patient we spoke with told us that they had received an appointment for a scan within a week of making a call to the service.

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.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. However, the complaints policy misrepresented the remit of the CQC.

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.

However, 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. The service also did not subscribe to any independent adjudication services that could support investigating complaints objectively when they could not be resolved locally.

Are Diagnostic imaging well-led?

Inadequate

We rated well led as inadequate.

Leadership

Leaders were visible to staff and understood the priorities of the service. However, they did not have full oversight of the service's policies and they did not support staff to develop their skills.

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 and administrative support.

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 registered manager. The registered manager did not have a formal system of monthly governance meeting where incidents, complaints, mandatory training rates were discussed and did not support staff to develop their skills and was unclear about the requirements of a practising privileges policy. Although consultants had a contract with the service, it was not clear that there was a practising privileges agreement and that the practising privileges policy had been discussed with them. Consultants should have a practising privileges agreement which should be reviewed by the service to ensure they carry out treatments, procedures or reporting that they are skilled, competent and experienced to perform.

Inadequate

Diagnostic imaging

Vision and Strategy

The service had a vision for what it wanted to achieve but the strategy did not detail how the service planned on achieving its goals.

The service had a vision which was to provide affordable scans and treatment for patients in the local community. Following the inspection, the service submitted a document titled 'vision and strategy' 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.

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.

Governance

The registered manager did not operate effective governance processes.

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.

During the inspection we asked to see minuted team meeting and governance meeting minutes however the service was unable to produce these. Following the inspection, the service submitted minutes of team meetings, but they did not contain detailed discussion or action points. Staff told us there were no formal team meetings and the registered manager would provide updates related to the service by email or as and when they met.

There were no clinical policies or written protocols relating to the scans undertaken at the clinic. Therefore, we could not be assured that scan reports adhered to national guidance or were in line with evidence-based practice.

During our inspection we were unable to find the duty of candour policy or practising privileges policy. Following the inspection, the service submitted these policies. We found that the practising privileges policy, which was drafted following the on-site inspection, stated that practitioners must participate in clinical risk management, audit and benchmarking programmes however the service did not carry out any of these activities.

We found that some of the provider's policies such as the safeguarding policy and medicines management policy, practising privileges policy and complaints policy, did not contain up to date guidance, reflected incorrect information, or was not sufficiently detailed.

Management of risk, issues and performance

Leaders did not use systems to manage performance effectively. They did not identify and escalate relevant risks and issues.

Staff told us the service did not undertake routine clinical and governance audits, which would allow the service to benchmark against other similar providers, and to identify changes that would improve the service based on information.

The provider did not have a comprehensive audit programme. The service audited patient feedback and hand hygiene but did not conduct other audits such as WHO checklist, infection prevention and control and scan reports. This meant that the service was not able to ensure effectiveness of the service as they were not monitoring areas to identify improvements.

The service had a risk register but it was unclear if this was reviewed regularly and the registered only identified environmental risks of the building rather than risks specific to the service.

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 but did not 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 but did not analyse it to understand performance, make decisions and improvements.

The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

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. Patient questionnaire results from the last 12 months were consistently positive.

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

Inadequate

Diagnostic imaging

Learning, continuous improvement and innovation

We did not see evidence that staff were committed to continually learning and improving the service.

The registered manager and staff had limited understanding of quality improvement methods for the service.

This section is primarily information for the provider

Enforcement actions

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
Treatment of disease, disorder or injury Diagnostic and screening procedures	Section 31 HSCA Urgent procedure for suspension, variation etc. **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;** **(b) doing all that is reasonably practicable to mitigate any such risks;** **(e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;** **(g) the proper and safe management of medicines;** **(h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;** • The ultrasound machine had not been PAT tested or serviced. • The service did not control infection risk well. We found that there was no cleaning log for the clinic room, chairs, examination couch and ultrasound machine which was visibly dirty. Although staff changed their gloves between patients, they did not wash their hands between patients. • We found a sharps bin which was full and had not been dated or signed which did not follow NICE guidance around the safe use and disposal of sharps. • The service had not actioned the National Patient Safety alert in relation to the safe use of ultrasound gel to reduce infection risk and was decanting ultrasound gel into bottles which had old dates on them. This was an infection control risk.

This section is primarily information for the provider

Enforcement actions

- The service did not have its own medicines management policy with detail around the medicines and procedures specifically related to the provider.
- We found that the contents of the anaphylaxis kit were in date however there was no log of checks for the kit to make sure everything was in date and nothing was missing.
- The service did not have a deteriorating patient policy.
- The provider did not ensure work was in line with evidence-based practice. The service did not have written clinical protocols and policies in place.
- Temperatures were not being monitored in the room medicines were kept.
- The service's safeguarding policy referred to out of date versions of national guidance and did not contain details on how staff can make a safeguarding referral.
- The service's policy for the scanning of children did not make clear that the service did not undertake interventional procedures for children.

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 service did not keep formal governance and team meeting minutes.
- The service did not have a comprehensive audit programme. The service audited patient feedback and hand hygiene but did not conduct other audits such as WHO checklist; IPC; scan reports.
- The service did not undertake quality assurance for the ultrasound machine Level 1, 2 and 3 as per British Medical Ultrasound Society (BMUS) Guidelines.
- We found that some of the provider's policies were missing, did not contain up to date guidance, reflected incorrect information, or was not sufficiently detailed.

This section is primarily information for the provider

Enforcement actions

- The service did not have a comprehensive risk register outlining the risks to the service specifically.
- The registered manager was not clear on the requirements of a practising privileges policy and did not ensure that the service followed its practising privileges policy.
- The service's complaints policy incorrectly stated that complaints can be referred to CQC for independent review.