

Virtual Cath Lab Surrey Ltd

The Virtual Cath Lab Surrey Ltd

Inspection report

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Date of inspection visit: 29 July 2021
Date of publication: 22/12/2021

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

Good 

Are services safe?

Good 

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 had not previously rated the service.

We rated it as good because:


- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well.
- Staff provided good care to patients. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients. Services were available in line with demand.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions.
- The service planned care to meet the needs of local people.
- People could access the service when they needed it and did not have to wait long for a diagnostic procedure.

However:

- Recruitment processes were not robust and some staff had started employment prior to written references being sought.
- Whilst staff told us they had an induction when starting work with the service, this was not documented and it was not clear if bank staff had completed an induction.
- Staff were not aware of the incident reporting process and policy. When incidents occurred, there was no evidence of learning that was shared with the team.
- Staff did not have any additional training on patients with individual needs, such as those with mental health issues or learning difficulties.
- Although there were some governance mechanisms, such as the medical advisory committee and the radiation protection committee, there were no meetings that all staff attended where governance issues were discussed. Team meetings took place but these did not follow a set agenda where governance issues could be discussed.
- Staff were not aware of the risks that were on the risk register, even though they were assigned as the risk owner. All risks on the risk register had been closed, most before they had been reviewed.
- Whilst people could give feedback easily, it was not clear how patients could raise formal concerns about care received.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	We have not previously rated the service. We rated it as good.

Summary of findings

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Summary of this inspection

Background to The Virtual Cath Lab Surrey Ltd

The Virtual Cath Lab Surrey Ltd is operated by Virtual Cath Lab Limited. Online, the service is called Heartscan Direct. It is a diagnostic and screening service clinic in Guildford, Surrey. The service primarily serves the communities of Surrey. It also accepts patient referrals from outside this area. All patients are privately funded. The service only saw patients who were adults aged 18 or over.

The service has a registered manager, who has been in post since January 2020, and is registered to provide the following regulated activity:

- Diagnostic and screening procedures

The service was registered in January 2020 and has not previously been inspected. New services are assessed at registration to check they are likely to be safe, effective, caring, responsive and well-led.

The service sees patients on a day case basis and has no overnight beds. Currently the only service provided is computerised tomography (CT). This is a type of scan that can help detect a variety of diseases and conditions. CT is fast, painless and non-invasive. CT is also used to diagnose or monitor diseases and to plan surgical or radiotherapy treatments.

The Virtual Cath Lab Surrey Ltd has one CT scanner and specialises in cardiac conditions. The waiting area, consulting rooms and some staff were shared under a service level agreement (SLA) with another service not covered in this inspection. The unit employed two radiographers on a part-time basis and had access to a further radiographer on the bank when required. Consultant cardiologists were employed via practicing privileges. Administration staff were shared with another service under an SLA.

Between 26 November 2020 and 6 May 2021, the service completed 260 CT scans. The majority of these were CT coronary angiography examinations, and the rest were coronary artery calcium scoring.

We carried out an announced inspection with seven day's notice on 29 July 2021 using our comprehensive inspection methodology: this was to ensure we could observe patient care on the day.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

How we carried out this inspection

During the inspection, we visited all areas within The Virtual Cath Lab Surrey. We spoke with the registered manager, both radiographers and members of the administrative team who worked under a service level agreement from the neighbouring clinic.

We spoke with two patients on site, reviewed several feedback responses and observed patient interactions throughout the day and watched three CT scans. We reviewed policies, guidance and information on performance and feedback provided to us before, during and after the inspection.

Summary of this inspection

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

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

Areas for improvement

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

Action the service **MUST** take to improve:

We told the service that it must take action to bring services into line with legal requirements.

- The service must ensure that recruitment procedures comply with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The service must ensure that governance mechanisms are effective and that all staff understand their roles and responsibilities. (Regulation 17 (1)(2) (a)).
- The service must ensure that all staff receive appraisals and supervision. (Regulation 18 (1)(2) (a) (c)).

Action the service **SHOULD** take to improve:

- The service should consider providing training to staff that ensures patients individual needs are met.
- The service should consider providing training to staff that ensures staff awareness and understanding of duty of candour.
- The service should consider auditing infection prevention and control processes.
- The service should consider that business continuity plans are shared with all members of staff.
- The service should ensure that risk registers are kept up to date and that there are mitigations and controls, and that these are regularly reviewed. (Regulation 17)
- The service should ensure that when incidents occur, learning from incidents is shared with the wider team. (Regulation 17)
- The service should ensure that all staff receive an induction that is documented as part of their staff record. (Regulation 18)






Our findings

Overview of ratings

Our ratings for this location are:

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

Diagnostic imaging

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

Are Diagnostic imaging safe?

Good 

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

Mandatory training

The service provided mandatory training in key skills to all staff and however not all expired training courses had dates booked for staff to complete.

Staff received mandatory training in a range of appropriate skills. There was no overall target for training compliance, but this was monitored via a spreadsheet on an electronic database. One of the radiographers had completed 25 out of 30 modules (83%) of training, and the other 20 out of 30 (67%). Incomplete or out of date modules were marked as red to highlight they required action.

Administrative staff employed under a service level agreement monitored mandatory training and alerted both administrative and clinical staff when they needed to update their training. However, there was no indication on modules marked red if any further training had been booked or what action was being taken.

Medical staff employed under practicing privileges did not complete training with the service, but from their employing NHS trusts. Proof of training was checked as part of the practicing privileges process.

Safeguarding

Staff had training on how to recognise and report abuse.

Staff received appropriate training in both adult and childrens' safeguarding. Radiographers and the registered manager received level two training for safeguarding adults which was in line with the Adult Safeguarding: Roles and Competencies for Health Care Staff Intercollegiate Document 2018

Diagnostic imaging

Radiographers completed level one safeguarding children training, and the registered manager was trained to level two in safeguarding children which was in line with Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff January 2019. Staff knew who to inform if they had safeguarding concerns. There had been no recent safeguarding issues but staff showed a good knowledge of what actions they would take if they had concerns.

Cleanliness, Infection Control and Hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas appeared clean and had suitable furnishings which were well-maintained. Hourly cleans of frequent touch points were carried out in the main reception area which we observed. In the CT scanner daily cleaning schedules were completed.

An external company cleaned at the end of the day. Between patients the radiographers cleaned the CT suite including frequent touch points, machinery, and equipment.

As part of a response to the COVID-19 pandemic, the service had updated its protocol and guidance for patients and visitors to the unit. Patients could use the waiting room prior to their appointment, however, accompanying visitors were asked to wait in outside to maintain social distancing within the waiting room.

Signage outside the clinic advised patients and visitors to wear masks unless they were exempt. On entry, staff asked patients to wear face coverings, use an alcohol based sanitising gel on their hands, and then to wash their hands in the patient toilet immediately afterwards. Staff ensured patients followed this process prior to being seen for their appointment.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE was readily available.

Cleanliness of the environment, equipment and hand hygiene compliance was not audited. Therefore, the service could not be assured that staff followed the provider's infection prevention and control policies and national guidance.

Staff used a mobile application on their personal smart phones to enter information during the procedure but there was no process in place to ensure the phone was cleaned before and after each patient. This was a possible infection control risk to the staff who took the phones off site. Staff had raised this as a concern and the registered manager was awaiting delivery of infection prevention and control approved tablets and covers.

At the time of our inspection the service had not completed a risk assessment about the management of infection control.

Environment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use specialist equipment.

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The waiting area was shared with another provider that VCL had a service level agreement (SLA) with. There was a range of chairs and staff limited the number of patients in the waiting area so that social distancing could be maintained. Screens had been put up at reception to aid distancing between reception staff and patients.

The design of the imaging environment followed national guidance. The CT scanner had restricted entry and only the radiographers had keys to access the area. The scanner was always locked when not in use. Signage that indicated the scanner was a controlled area. Staff working in the scanner wore radiation dose badges that measured the amount of radiation they had been exposed to.

The CT scanner suite was modern and had additional features such as mood lighting and also an image of clouds on the ceiling to help the room feel less enclosed.

Staff carried out daily safety checks of specialist equipment. Staff carried out quality assurance checks of the CT scanner daily with additional monthly checks and this was recorded and documented. Resuscitation equipment shared by the service and the neighbouring clinic was checked daily and equipment on the resuscitation trolley was kept secure by tamper evident tags. When patients were being scanned, the trolley was moved from the clinic area into the corridor between the scanner and the clinic area, so all staff could access equipment quickly if needed. Signage showed where emergency equipment such as defibrillators were stored.

The CT scanner and suite were leased from a third-party company who were responsible for servicing and for fixing any faults. Information was available for radiographers to contact them to report faults and we saw the fault log. Incidents involving equipment faults was escalated to the radiation protection advisor (RPA) who provided support. Actions that had been taken following repair was documented in equipment folders.

"Local rules" for the CT scanner and staff was displayed in the suite in line with Ionising Radiation Regulations 17. A CT radiation risk assessment had been completed by the radiation protection advisor (RPA).

Assessing and responding to patient risk

Staff completed risk assessments regarding radiation. Staff used checklists before procedures to minimise the risk of side effects.

The service made changes to practice to minimise risks during the COVID-19 pandemic. Patients were contacted before attending to ask about possible symptoms. Only the patient was allowed into the unit unless there were special circumstances such as disability or mobility issues.

Staff wore masks whilst in the unit and tested weekly for COVID-19. Any staff showing symptoms were required to follow national guidance on further testing and isolation.

Contrast was used with certain types of CT scans. Contrast is a special dye injected intravenously to help improve the quality of the images. Injecting contrast is low risk but can cause side effects. Contrast checklists completed by the patient before the procedure were checked and confirmed by the radiographer to help minimise the risk of side effects. Staff told us they had access to relevant test results when required.

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There were policies outlining what actions to take for procedures that carried a level of risk. For example, the Extravasation Policy dated July 2021. Extravasation can occur when contrast is injected into the vein and leaks into the tissues under the skin. It outlined the signs and symptoms of adverse reactions to contrast agents and that any reaction should be documented in the patient's record. It also detailed that patients should be given a leaflet explaining what extravasation is and how to manage the symptoms.

An emergency buzzer had recently been installed into the CT scanner. Staff said this had been checked recently, however this was not documented. We saw an emergency alarms weekly checklist, however this was only completed up to December 2020.

Staff explained that in an emergency, they would call 999 and could open a side door for ambulance access. Clinical staff were trained in both basic life support and immediate life support. A doctor was also always on site to assist until emergency services arrived on the scene.

There were procedures for checking patient identification and pregnancy where appropriate as part of Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) employer's procedures.

Society of Radiography 'pause and check' posters were displayed in the unit. These were aide memoires to remind staff to check essential information prior to carrying out the procedure.

There was a policy for "Other Structure reporting (incidental lung nodules and anomalies) and referrals for dual practitioner justification". This ensured any incidental findings such as lung nodules and other anomalies that called for further investigation were acted upon by the reporting clinician.

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. However, it was not clear whether staff received formal inductions.

The service had enough staff to keep patients safe. The service employed two radiographers, used administrative staff from the cardiac clinic under a service level agreement (SLA) and had a number of consultant cardiologists and radiologists under practicing privileges.

One of the radiographers was the radiation protection supervisor (RPS). The role of the RPS is to oversee the radiation work to ensure the local rules are followed. Staff files showed the RPS had received appropriate training; however, there was no evidence of a formal induction documented in either radiographers' files.

The RPS had handed their notice in and the second radiographer was waiting to complete their RPS training to take on the role. There were two radiographers on the bank on an as required basis, that could be used in the event of sickness or leave. There was no evidence bank staff members had received an induction.

Radiographers completed CT competency training on the CT scanner. We saw both radiographers had completed this.

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There were a number of consultant radiologists and cardiologists were employed under practicing privileges. There was a process in place to ensure that any consultants wishing to work for the service were appropriately vetted and interviewed prior to commencing with the service. This process was outlined in the practicing privileges policy and overseen by the medical advisory committee.

Additional medical staff were always on site and available to assist in an emergency when the service was operating due to the service sharing clinic space with the neighbouring cardiovascular clinic.

The service did not use agency staff.

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 notes were comprehensive and available via the internal computer system. The registered manager said the service was nearly paperless but some paperwork such as the contrast checklist still existed. Administrative staff scanned hard copy results into the electronic records after the patient procedure.

A secure online application had been rolled out in July 2021 which made it easier for radiographers to enter information in real time during the scan, including radiation dose and medicines used. Most fields were mandatory which meant that information was consistently collected. However there was a delay on the availability of the electronic handheld tablet devices that had been purchased and staff had been using their personal mobiles to enter the data. Data was not stored on this app and therefore not considered an information governance risk. Following our inspection we saw that a risk assessment had been made of this concern, however no controls or mitigations had been recorded.

The images were available after the scan to be sent to a secure picture archiving system and were stored in the service 'cloud' storage system. Patients could also request the images onto a CD at an additional cost.

Medicines

The service used systems and processes to administer, record and store medicines.

The only medicines used by the service was contrast, an iodine-based dye injected intravenously to help improve the quality of the images and beta blockers, a medicine used to reduce and regulate a patient's heart rate during their scan.

Medicines were kept securely and locked in a cupboard in the CT scanner when not in use. Ambient room temperature checks were performed and recorded to ensure the contrast was kept at the appropriate temperature.

Radiographers used a patient group direction, which is a written instruction allowing non-medical staff to administer a group or type of medicines without a prescription, to administer contrast and consultants prescribed beta blockers. Radiographers carried out checks prior to the patient being scanned to ensure that the patients were not taking any medication that may interfere with the contrast being injected.

Incidents

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Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents but did not share lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. Staff said they used an incident logbook to record incidents and gave an example of a patient collapse the day prior to our inspection. However, when we asked to see this, the book could not be located. Following the inspection, we were sent electronic copies of the reports.

There was an incident reporting policy, however, it was not clear in the policy how staff were to record incidents. Radiographers described how to report an incident involving Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and described escalating to the radiation protection advisor (RPA) at the nearby hospital, however this was not covered by the policy.

Staff told us that during an incident where a patient's heart had stopped whilst in the scanner, they had received a de-brief with the team. Following the inspection we requested a copy of the incident report. The incident had been documented including in the patient's notes. However, there was no evidence of individual feedback or that incidents or learning from incidents was discussed as a team or at team meetings.

An incident report for a patient collapse was documented on a different report form from the other incident report reviewed which showed some inconsistency in approach. It had a risk grading for incident, and space for any further comments or actions. This report identified the need for manual handling training, but it did not indicate who was responsible for following up this action or a completion date. This meant that identified actions may not be resolved.

We received a duty of candour policy following the inspection. This was dated August 2021 indicating it was not previously in place. At the time of the inspection there was no training in duty of candour.

The service had not recorded any serious incidents or never events since it started providing services. There had been no radiation incidents that had required reporting under IR(ME)R.

There was accident and incident report training but only one of the two radiographers had completed it.

Are Diagnostic imaging effective?

Inspected but not rated 

We do not rate diagnostic services. We inspected but did not rate effective.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

As the service had been running for less than 12 months at the time of our inspection, there were limited audits to prove compliance with relevant guidance from the National Institute for Health and Care Excellence.

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We noted that the service had a policy 'Monitoring Quality Management of Treatment and Care' which specified that it was the responsibility of individual teams to complete audits and to ensure that they were fed into the relevant meetings to be noted and discussed.

The service ensured radiation doses were kept as low as reasonably practicable by auditing patient doses over a period of time. In the most recent audit, lower doses were achieved following recommendations for optimisation of the scanner.

The results of this audit were discussed at the radiation protection committee meeting and ongoing actions were discussed and agreed. The service was waiting a full year's audit results to be able to compare how the local practice compared to national practice. An audit showed that 100% of coronary artery calcium scoring were reported by cardiologists, in line with best practice and with the service's policy. The service adapted the way it worked to ensure it functioned in line with current COVID-19 guidance. Footfall in the waiting area was monitored and limited to ensure social distancing was maintained, screens were installed at the reception areas and hand hygiene points were some of the measures used to minimise risk of infections.

Nutrition and hydration

The service had facilities to provide hot drinks and water to patients. Due to COVID-19 guidance, staff prepared patients' hot drinks to reduce the number of people using the communal machine.

Pain relief

Staff assessed and monitored patients regularly to see if they were comfortable and gave reassurance. Patients were not given pain relief but staff ensured patients were kept comfortable during their CT scans.

Patient outcomes

Staff collected and analysed data to enable them to monitor the effectiveness of care and treatment.

As the service had been running for less than 12 months at the time of our inspection, there was limited data to show patient outcomes. However, the service demonstrated that it was committed to collecting data so it could demonstrate outcomes in the future; this was evidenced by a number of completed clinical audits. A patient outcome audit showed that during quarters one and two of 2021, the majority of patients (61%) needed no further action following their scan. The audit also recorded patients who required further discussion at a multidisciplinary team meeting, additional scans or appointments. Staff conducted an 'appropriateness' audit of a sample of 12 CTs completed in the first and second quarter of 2021. The audit measured whether the referral and the test selected by the practitioner were appropriate, if referral information was of good quality, and if the test had been useful.

Multidisciplinary working

Healthcare professionals worked together as a team to benefit patients.

Effective multidisciplinary meetings were held when needed to discuss patients and improve their care. The service was made up of radiographers and consultant cardiologists who worked together for the benefit of the patient. Consultant radiologists were employed via practicing privileges and were used by the service when required. The service used a multidisciplinary team review in certain circumstances. For example, if a CT scan resulted in a recommendation that was

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urgent such as urgent stenting, the images and report were reviewed by a multi-disciplinary team for a second opinion. We saw examples of images that had been referred for MDT discussion, and found that these were appropriate and included the details of the name of the consultant that had reviewed the images. The service audited the number of patients that were referred for an MDT discussion, and in the first two quarters of 2021, 5% of patients were referred.

Seven-day services

The service operated two days a week from 9am to 6pm in line with demand.

Competent staff

Whilst the service made sure staff were competent for their roles, managers did not have any plans for appraising staff's work performance and no supervision meetings were held with them to provide support and development.

Staff had been at the service for less than a year and so were not due an appraisal. However; they were unclear who would be completing their appraisal or when it would occur. They were not aware of how their professional development would be managed or by whom. There were no formal check-ins or clinical supervision available.

Staff files were held on an electronic system that was password protected. The process for employing staff was outlined in the recruitment policy, however the policy did not specify that employment references or disclosure and barring service (DBS) were required prior to commencing employment.

We requested copies of staff references following the inspection as we did not see them in the staff files. The registered manager informed us that only verbal references had been obtained prior to the employment of the two radiographers following telephone and online conference calls, but this was not documented in the staff members' files. As a result, the registered manager applied for written references for both staff members in August 2021.

We saw that the radiation protection supervisor had attended a relevant training session for their role.

Consultants wishing to work under practicing privileges had to have substantive NHS contracts, take part in weekly NHS MDT meetings and complete a minimum number of procedures per year to be considered. We reviewed two consultant files employed under practicing privileges. We saw evidence of appraisals and other relevant documentation.

Managers made sure staff attended team meetings between the neighbouring cardiac clinic and VCL. Notes were taken and made available on the shared drive for all to access. Notes from a meeting dated 6 July 2021 with the practice manager and two directors discussed the upcoming changes to guidelines on COVID-19, and a meeting between both services in May 2021. However, there was no formal schedule for meetings and no set agenda.

Staff told us they received an induction upon starting work with the service, however the induction was not documented on staff files.

Consent, Mental Capacity Act and deprivation of liberty safeguards

We saw that consent was discussed and recorded prior to scans. Consent was also discussed with the patient at the clinic appointment, with the radiographer and cardiologist.

Diagnostic imaging

Consent was documented on the contrast checklist that was part of a discussion prior to the procedure and on the application used to document the procedure.

Staff completed training in the Mental Capacity Act and both radiographers had completed this training within the last year.

Are Diagnostic imaging caring?

Good 

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed caring patient interactions by administration staff and radiographers.

Patients said staff treated them well and with kindness. We spoke to two patients on the day of our inspection and comments included “seamless process”, “staff were helpful and informative”.

The service had re-started obtaining patient feedback in June after stopping during COVID-19. The feedback form consisted of four smiley faces which patients chose to reflect how they felt about the service. Forms were given to patient following their scan with a hot drink whilst they waited to check for any after-effects from the contrast. In feedback received from June to July 22nd, 19 out of 23 (82%) respondents gave the maximum smiley face. Comments included: “very welcoming and friendly”, “carefully explained” and “perfect in every aspect.”

Staff ensured that patients care and treatment was kept confidential. Computer screens were locked when not in use and a room was available if patients wished to have a private conversation on arrival. Printed lists on desks were placed face down when not in use and were kept out of reach of patients and visitors.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

The chaperone policy was in date and outlined staff responsibilities and processes. The practice manager who was under a SLA from the neighbouring clinic had received chaperoning training and was able to act as chaperone if needed.

We observed staff gave patients space and time during their consultations to ask questions. We saw a comment on a feedback form that stated a patient had felt nervous about their procedure but that they had felt supported by the staff.

Understanding and involvement of patients and those close to them

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Staff supported patients, families and carers to understand their condition. Staff made sure patients and those close to them understood their care and treatment.

Staff ensured any queries were answered before scanning commenced and at several times for each patient at referral, by consultant and by radiographer. The provider's website had a 'frequently asked questions' section.

Staff ensured patients felt supported following their scan. Patients were required to sit in the waiting area following their scan for 15 minutes, during which time the radiographer ensured they were comfortable and provided with a hot drink. After 15 minutes the radiographer returned, checked the patient felt well and made sure they did not have any further questions.

Are Diagnostic imaging responsive?

Good 

We have not previously rated the service. 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. It also worked with local organisations to plan care.

The service currently ran two days a week which was in line with demand for the service. Initial appointments could be held via a video conferencing service if patients wished, but the service also offered face to face appointments.

The service worked with the neighbouring clinic to enable patients that needed multiple diagnostic tests to have them all in one appointment session. For example, patients could have blood tests and ECGs, on the same day as their CT appointment.

Facilities and premises were appropriate for the services being delivered. There was a large waiting area with comfortable seating. Patients could park in a designated car park owned by VCL that was next to the clinic.

During the COVID-19 pandemic, the service stopped using the waiting room in order to minimise the footfall of patients, and instead asked patients to wait in the car until they were called, and would be met by a member of staff who led them through the unit to the scanner.

Meeting people's individual needs

The service took account of some patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. However, staff were not given additional training on patients' individual needs and preferences.

Wheelchair users were able to access the service. The main entrance was accessible via a ramp and the toilets were wheelchair accessible. The CT suite was also accessible to those in wheelchairs.

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Managers made sure staff and patients could get help from interpreters or signers when needed. Staff could access an interpreting service for those whose English was not a first language by booking online in advance of the appointment.

Staff did not complete training about people who may have additional needs, learning difficulties or mental health conditions. Staff told us that this was because the patients that access the service were usually 'worried well' people and this meant that generally this cohort of patients did not have other co-morbidities. However, this meant the needs of patients who wished to access the service needs' may not be identified or met.

Access and flow

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

All patients were self-funding and there were no NHS contracts at the time of our inspection. Patients could be referred to the service by two routes. Symptomatic patients were referred from a cardiologist or GP in the NHS or private sector. Asymptomatic patients who were concerned could approach VCL directly for a consultation with a cardiologist, who may then refer on for further tests including CT. All appointments were pre-booked.

Only a cardiologist was able to justify a request for CT-calcium scoring or CTCA scan and there was no 'self-referral' for CT scanning.

Staff had completed a referral appropriateness audit which sampled 12 random cases from the 275 CTs completed to date and found that all cases reviewed were appropriate.

Reports following the scans were turned around within 24 hours. VCLS Medical Advisory Committee (MAC) stipulated a 24-hour limit for the cardiology report to be produced. The results were shared with the GP or referring clinician unless the patient expressly stated they did not want this.

All referrals were electronic and the majority came from consultant cardiologists. Electronic referrals meant that referrals were 'instant' and could be processed quicker than paper referrals.

Patients were offered a choice of appointment times on the two weekdays that scans were held. Patients told us they had been seen quickly since their referral, with one being seen the next day. Patients were seen promptly on arrival to the unit.

Learning from complaints and concerns

Whilst people could give feedback, it was not clear how to raise concerns about care received. The service had a policy that outlined when complaints should be responded to.

The service had a complaints policy. It outlined that complaints would be acknowledged within two working days but there was no definition for when the final response would be received. The registered manager informed us that there had been no complaints received since the service began operating.

It was not clear how patients should make a complaint or raise concerns. Whilst there were feedback forms given to patients after their scan, there was no guidance on the website or any leaflets visible in the waiting areas to let people know how to raise concerns or make a complaint.

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Are Diagnostic imaging well-led?

Requires Improvement 

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff, although staff reported that managers were very busy.

The registered manager had responsibility for the overall management of the clinic and was supported by a practice manager who was employed under a service level agreement from the neighbouring clinic, which had the same registered manager.

Staff told us that the registered manager's visits were often short and there was not always the opportunity for staff to have meaningful discussions. The registered manager was also the registered manager for the neighbouring clinic, worked in the NHS and worked in another private organisation. During the inspection we observed the registered manager work clinically and provide ample time to patients to ensure they received the best possible service. However, the registered manager was continually busy. This meant they may not have been able to support the staff or fully embrace their function as a CQC registered manager.

Staff reported that whilst the registered manager was approachable, they were not clear of their lines of accountability. For example, staff did not know if or who would complete their appraisal. The registered manager and medical director were both considered approachable but staff told us that they were always very busy, with both having NHS work alongside the VCL work resulting in very short visits to VCL.

Following our inspection, the registered manager informed us that they had made changes to their work schedule in order to provide staff with 'quality time' whilst in the service. They reported that from November 2021, they will be present at the service for non-clinical duties in order to attend meetings with staff and to allow one to one time with team members.

Vision and Strategy

The service did not have a formal vision or strategy for what it wanted to achieve.

There was no specific values or strategy. The registered manager explained that the vision was to extend services to other clinics in the UK, however there was no formal strategy in place to turn this into practice. The service's website stated that the service was "dedicated to transforming the delivery of cardiovascular imaging and to increase the capacity of these life-saving tests within the whole healthcare system."

There was an agreement in place to ensure specialist equipment was future proofed. The service leased their CT scanner through a third party and thus any replacements or upgrades were covered by this agreement.

Diagnostic imaging

Governance

There were some effective governance processes, throughout the service, however not all staff at all levels were clear about their roles and accountabilities or had regular opportunities to meet, discuss and learn from the performance of the service. Recruitment processes were not robust.

The process for employing staff was outlined in the recruitment policy, however, the policy did not specify that employment references or disclosure and barring service (DBS) certificates were required prior to commencing employment.

The service did not ensure that staff underwent pre-employment checks as required by Schedule 3 of the HSCA 2008 (Regulated Activities) Regulations 2014. References detailing evidence of conduct in previous employment were not obtained prior to staff commencing their role. Following our inspection written references were sought.

The medical advisory committee had met three times at the time of our inspection. There was a standing agenda that included review of complaints and incidents. However, there were no meetings where the service risks could be discussed, reviewed or updated.

There were no governance meetings that all staff could attend. For example, staff meetings were sporadic and had no set agenda where items such as complaints, learning from incidents or risks were discussed.

The 'how we process, and check referrals' policy was dated and version controlled. However, the policy contained out of date information about a third party company that was no longer working with the service.

Practising privileges policies stated all consultants must either hold a consultant appointment in an NHS hospital or be listed on the specialist register of the General Medical Council and we observed that this policy was being followed.

It was not clear who was responsible for the governance of SLAs held by the service. We reviewed the SLA held between the service and the adjoining service. It was created in 2019 and stated was for an initial period of 12 months. However there had been no review or update of the SLA since it started.

The service held two meetings where governance items were discussed. The radiation protection committee (RPC) and the medical advisory committee (MAC). The RPC meeting fed into the MAC meeting and there was a standing agenda item on the MAC agenda to review the latest report from the RPC.

The radiation protection committee meeting had its first meeting in October 2020. We saw from the minutes of this meeting that the local rules, policy and terms of reference were confirmed.

Management of risk, issues and performance

There were no effective systems in place to identify, review and escalate service level risks. There were plans to cope with unexpected events but not all staff were aware of this.

The service's risk register was sent to us following the inspection. The two biggest risks to the service, following mitigating actions were high risk patients that might have cardiac conditions, or failure of the workstation leading to a delay in patient care. However all of the risks had been closed in October 2020, and some closed before their review date.

Diagnostic imaging

Staff told us they thought the biggest risks to the service were staffing as without radiographers the scans could not go ahead. The radiographers were listed as risk owners for some risks but they were unaware of this.

A CT radiation risk assessment had been completed by the radiation protection supervisor (RPA) prior to the service commencing.

Two risk assessments were sent to us following the inspection. One was regarding the amount of information being entered on reduced paperwork, dated December 2020, the other was regarding the use of personal phones being used to input patient data via an app, and the IPC risks this presented. There were no control measures listed and no date to review the risk.

There was a service business continuity plan but staff were unaware of this or its contents.

Culture

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

Staff felt supported on a personal level. However, we found no evidence of formal check-ins or clinical supervision processes to support staff professionally. Some staff felt undervalued and their professional role was not fully understood or appreciated. Staff said that they did not feel complete ownership over their work, for example not being in control of their own stock as this task had been given to an administrative member of the team. There was a feeling the radiography role was not fully understood and therefore not enough support was given.

There was no process to obtain views of staff leaving the service employment such as exit interviews to ensure views from staff leaving the service were captured. This meant the provider was missing an opportunity to learn from feedback and improve retention as a result.

Staff told us that the managers were approachable and that they felt they could raise concerns with them.

Engagement

Leaders and staff engaged with patients to manage services. They collaborated with partner organisations to help improve services for patients.

The service asked for feedback following each scan whilst the patient was offered a hot drink. Responses could be kept anonymous if they wished and responses were placed in the mailbox on the wall which would later be collected by staff to review. The feedback we reviewed was largely positive.

The provider had information on two different websites. One was heartscandirect.com and one was the neighbouring clinic website.

We reviewed minutes from staff meetings and saw that updates on government guidelines and administrative functions were discussed. However there was no standard agenda and it was not clear whether staff had the opportunity to contribute or ask questions. Notes from the meetings were scanned onto the computer system so that staff could access them if they were unable to attend.

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

Diagnostic and screening procedures

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The service must ensure that governance mechanisms are effective and that all staff understand their roles and responsibilities. (Regulation 17 (1)(2) (a)).

Regulated activity

Diagnostic and screening procedures

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The service must ensure that all staff receive appraisals and supervision. (Regulation 18 (1)(2) (a) (c)).