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Leeds Screening Centre

Inspection report

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Date of inspection visit: 23/11/2021
Date of publication: 08/02/2022

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

This is our first inspection of this location. We rated it as requires improvement because:

- We had concerns about aspects of infection prevention and control (IPC) in the service such as the location of the only sink, the use of alcohol gel rather than handwashing as the primary method of hand decontamination, disposal of clinical waste, open top bins and the location of the sharps bin. Additionally, some chairs and beds had deteriorated and did not meet IPC standards because they could not be properly cleaned.
- The provider kept staff files, but these were not all up to date and did not all contain the full information required to demonstrate a robust recruitment process had been undertaken.
- Not all staff were confident about who to contact in the event of a safeguarding concern, staff had not undergone training about recognising domestic violence and the safeguarding lead did not meet intercollegiate standards with the level of safeguarding training they had undergone.
- Some patients commented and we saw that there were no blinds or curtains in place around beds to protect the privacy and dignity of patients.
- Some staff were unclear about what incidents and near misses they should report to the management team although there was a policy for staff to refer to.
- The service did not have a robust process for supporting patients whose first language was not English and who needed an interpreter or signer. The service did not have a process in place to make sure information passed on to patients by nonprofessional interpreters was accurate and complete.
- The provider was not able to provide quality checked leaflets in languages other than English.
- The provider did not have a specific policy in place to support staff managing patients who had additional support needs such as a learning disability, sensory impairment or dementia.
- Meeting minutes were not comprehensive and did not detail discussions or actions taken during meetings. They were not a clear record of meetings.
- There were breaches in regulations and risks within the service that had not been identified by the management team. Therefore, there was no mitigation in place to reduce risks or address regulation breaches.

However:

- The provider was able to show us policies, procedures, risk assessments and standard operating procedures they used to make sure patients were safe from the risk of harm.
- There was information for staff working at the service about their responsibilities in relation to clinical records and clinical records contained sufficient information to make sure patients were safe.
- Staff who worked for the service had the appropriate qualifications, skills and experience to make sure patients received care and treatment that was safe.
- There was a process in place to assure the provider that staff had an up to date registration and revalidation.
- The building was easy to access for those with a disability.
- Cleaning equipment and substances hazardous to health were locked away.
- Portable appliance testing (PAT), servicing and calibration, were completed and up to date.
- The provider was able to assure us that staff followed the correct process to obtain patient consent.
- Staff received annual appraisals and could access training to make sure their knowledge remained up to date. Staff training was up to date and there was a training plan in place for all staff.
- The provider gathered feedback from patients about their experiences of the service.
- There was information about how to make complaints displayed and the manager of the service dealt with complaints. Lessons learned were fed back to staff at quarterly staff meetings.

Summary of findings

- Social media feedback and feedback gathered by the provider was predominantly positive and patients felt cared for, well informed, supported and involved in the care and treatment they received.
- There were governance processes in place, and these included how the provider monitored performance to ensure care and treatment was delivered in line with national guidance and work to improve the services delivered to patients.
- Clinical audit was carried out. Although this had been limited in the past 12 months because of the pandemic, the manager had plans in place for the coming 12 months which would see this increase.
- The provider worked closely with local NHS trusts to provide services in a joined up cohesive way and there were systems in place to monitor contracts and the quality of services delivered.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Requires Improvement 	We rated it as requires improvement because: • There was a lack of evidence that all staff understood how to protect patients from abuse or identify those at risk of abuse including domestic violence. The service did not control infection risk well. The service had a process in place to manage safety incidents and learn lessons from them however some staff were not confident about the type of things they should report. Recruitment records did not demonstrate robust recruitment processes. The service had enough staff to care for patients. • There was evidence to show staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. There was evidence staff supported patients to make decisions about their care. Services were available by appointment only. Staff worked together for the benefit of patients. • The service planned care to meet the needs of their patients and took account of patients' individual needs however if a patient's first language was not English the service often used online translation applications to communicate which increased risks to patients. There was a process for people to give feedback. People could only access the service by appointment but did not have to wait too long for treatment. • Leaders ran services using reliable information systems however there were risks and regulation breaches which the leadership team had not identified and were therefore left unmitigated and not addressed. Staff were supported to develop their skills. There was clarity from the provider about staff roles and accountabilities. The service had engaged with stakeholders to plan and manage services.

Summary of findings

We rated this service as requires improvement overall because we found safe and well led to require improvement. We rated effective, caring and responsive as good.

Summary of findings

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Summary of this inspection

Background to Leeds Screening Centre

Leeds Screening Centre is registered for the regulated activity of diagnostic imaging and treatment of disease, disorder or injury. Patients can either contact the clinic directly to book an appointment or be referred by either a GP or other provider.

Leeds Screening Centre carries out ultrasound procedures, pregnancy scans and blood screening.

The clinic has a registered manager who has been in post since the clinic opened in 2015.

This is our first inspection of Leeds Screening Centre at this location.

What people who use the service say

We looked at reviews of the service on social media and asked the service for their latest patient survey results. There were a limited number of reviews relating to the previous 12 months on social media.

Leeds Screening Centre had received mostly positive feedback about the care and treatment people received at the clinic in the past 12 months both online and from their internal patient satisfaction survey.

Most patients made comments about how well they were looked after and how professional, kind and caring staff were throughout consultations and procedures however some patients said they were disappointed by the service they received because they felt rushed or had a long wait once in attendance.

How we carried out 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.

This was an unannounced comprehensive inspection. One CQC inspector and a specialist advisor carried out the onsite 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 the following legal requirements. This action related to treatment of disease, disorder or injury, surgical procedures and diagnostic and screening procedures:

- The provider must ensure that infection prevention and control policies are followed. (Regulation 12(2))

Summary of this inspection

- The service must ensure staff are able to demonstrate they would recognise possible abuse and be clear about who should be contacted if there is a concern about a person being the victim or at risk of abuse. (Regulation 13)
- The service must ensure systems or processes are established and operated effectively to ensure staff are recruited in full accordance with Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA regulations)(Regulation 19).

Action the service should take to improve:

- The provider should make sure bins in clinical areas have pedal opening lids, so waste is enclosed after disposal.
- The provider should make sure clinical waste and sharps bins are easily accessible to all applicable staff and located in all clinical areas where they will be used.
- The provider should make sure furniture within clinic rooms such as drawers, beds and chairs meet infection prevention and control standards.
- The provider should make sure there is a system to call staff and patients in case of emergency.
- The provider should make sure all staff know where emergency equipment such as defibrillators are located.
- The provider should make sure the privacy and dignity of patients is protected by having blinds or curtains in place around beds.
- The provider should ensure all staff have undergone training about the signs of domestic violence.
- The provider should make sure all staff have a good understanding of what they should report as an incident or near miss and are confident to do so.
- The provider should make sure patients whose first language is not English and need an interpreter have access to interpreting and translations services to make sure any information passed to them is accurate.
- The provider should ensure there is a policy staff can access to support them in managing patients who have additional support needs such as a learning disability, sensory impairment or dementia. This should include training about deprivation of liberty and capacity to make decisions.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic and screening services	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Diagnostic and screening services

Safe	Requires Improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Are Diagnostic and screening services safe?

Requires Improvement

We rated Safe as requires improvement.

Mandatory training

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

The provider delivered statutory training. This was delivered online and at staff meetings. Staff also accessed training via their main employer.

The service had a process to make sure everyone was up to date with their mandatory training.

The provider had a system in place, including completed records to ensure all staff were up to date with all their training requirements. They had a process for gathering evidence to provide them with assurance or to alert staff when they needed to update their training.

Safeguarding

Staff did not understand how to protect patients from abuse or work well with other agencies to do so. Staff had training on how to recognise and report abuse, but they were not confident about how to apply it.

The safeguarding lead did not have the level of training specified by intercollegiate guidance to hold the role of safeguarding lead at the time of the inspection however they completed it online shortly after the inspection.

We were not confident that all staff would recognise abuse, know how to report it or who to report it to.

Staff did not fully understand their responsibilities in identifying adults and children at risk of, or suffering harm. Staff had not completed training in how to identify the signs of possible domestic violence.

Staff did not know how to make a safeguarding referral and were unable to articulate which other agencies they should inform to protect patients.

There was a safeguarding policy for staff to refer to.

Cleanliness, infection control and hygiene

The service did not control infection risk well. Staff did not use equipment and control measures to protect patients, themselves and others from infection.

Clinic rooms did not have their own sinks. The service only had one sink and this was used by staff and patients alike. It was located in the reception area. There was an increased risk of cross contamination because of this.

Clinic rooms did not have clinical waste bins nor did they have pedal bins with lids. We found open top bins in the clinic rooms. Staff had to take any clinical waste to the only clinical waste bin which was located in the reception area.

We saw beds and chairs were not in good order and there were holes in them. This meant that they were not infection prevention and control compliant and increased the risk of spreading infection because they could not be cleaned properly.

Staff were observed sometimes only using hand gel between patients rather than fully washing their hands. Alcohol hand gel is not a substitute for thorough hand washing as a method of hand decontamination and therefore there was an increased risk of spreading infection because of this.

When we arrived at the service, we observed some staff were not wearing face masks, however once the inspection was announced, staffed donned face masks. PPE was available for staff use and masks were available for patients to wear.

Although there was hand gel available for patients, staff were not pointing it out to patients or encouraging them to use it.

We observed staff cleaning equipment such as probes after patient contact and labelling equipment to show when it was last cleaned.

The clinic rooms and reception were visibly clean.

The provider showed us cleaning rotas and daily cleaning records. Although staff had not initialled every time they carried out a check and had simply drawn a line from top to bottom, we did have some assurance that cleaning took place.

Environment and equipment

The maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Clinical waste was not stored in an appropriate location. Resuscitation equipment was available in the building but not all staff knew where it was located.

Clinic rooms did not have an emergency call button and toilets did not have an emergency pull cord. We therefore had some concerns about how staff and could call for emergency help.

There was enough suitable equipment to help staff safely care for patients. Staff had undergone training about how to use equipment. However, the service did not have an armrest chair to support phlebotomy patients and phlebotomists when taking blood.

Requires Improvement

Diagnostic and screening services

On inspection, stock was stored in locked cupboards and we were assured that staff could access equipment and stock easily when needed.

The service had suitable facilities to meet the needs of patients' families such as a waiting area which supported social distancing.

The service did not have a resuscitation trolley however there was a defibrillator in the building that staff could access. One member of staff however told us they did not know where the defibrillator was kept.

Not all clinic rooms had curtains or blinds around beds and therefore there was a risk that patient's privacy and dignity were not preserved.

Assessing and responding to patient risk

Staff completed risk assessments for patients. We found evidence of how staff identified and quickly acted upon patients at risk of deterioration.

Staff completed basic risk assessments for each patient to remove or minimise risks. Individual clinicians carried out risk assessments at initial consultation.

Staff could identify and quickly act upon patients at risk of deterioration although the risks were minimal due to the patients who used the service.

There were policies in place for staff to refer to about and dealing with any specific risk issues such as scan anomalies. Staff knew the action they should take if they had any concerns about scan results and who to refer patients to when they had concerns.

Nurse and Allied Health Professional staffing

The service had enough nursing and allied health professionals to keep people safe. We were assured that all staff had the right qualifications and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The provider knew what skills and qualifications staff should have to enable them to fulfil their role safely.

Staff records contained information about registration and revalidation checks therefore we were assured the provider had carried out the necessary checks.

The provider carried out annual appraisals of staff. Staff told us they also had 1:1 meetings however these had become less frequent as a result of the pandemic.

Medical staffing

Due to the nature of the service provided, there were no medical staff employed by the service.

Staff could contact radiologists from the local acute trust for support if they needed help with a scanning issue.

Requires Improvement

Diagnostic and screening services

Records

Staff kept records of patients' care and treatment. Records were stored securely on an electronic patient record and easily available to all staff providing care.

The provider showed us how records were stored securely using different software.

Staff kept records of patients' care and treatment such as scans. Records were clear, up-to-date, stored securely and followed a retention policy.

We checked six sets of clinical records during our inspection. These contained sufficient information within them to ensure patients were safe and received the care and treatment they needed.

Information about patient scans was shared with GPs and other organisations in a timely way.

Medicines

The service did not use medications within the service.

The registered manager told us the service did not use any medicines such as pain relief for patients and did not store any contrast medium used in some scans.

Ultrasound jelly was stored correctly and in date.

Incidents

Staff were not confident about reporting incidents and near misses. When something went wrong, we had no assurance staff reported this. Managers made sure actions from patient safety alerts were implemented and monitored. Managers said they would investigate incidents and share lessons learned with the whole team and the wider service if there were any.

Two staff we spoke with were unclear about how to report incidents or what type of incidents they should report therefore we were not assured that incidents would be reported appropriately. We had no evidence to corroborate whether staff raised concerns and reported incidents and near misses if they happened.

The provider told us lessons learned from incidents were shared with staff at quarterly meetings. Because there were no reported incidents in the past 12 months there was nothing recorded in staff meeting minutes. Therefore, we were unable to corroborate this.

The manager told us there had been no incidents reported within the last 12 months however one member of staff told us about an information governance breach. We were therefore concerned about the robustness of the incident reporting process.

The staff we spoke with had some understanding of duty of candour and their responsibilities to be open and transparent and give patients and families a full explanation if and when things went wrong.

We were unable to assess whether managers debriefed and supported staff after a serious incident because there had been no serious incidents. Staff did tell us they felt they would be supported if something serious happened.

Requires Improvement

Diagnostic and screening services

Are Diagnostic and screening services effective?

Good

We rated effective as good.

Evidence-based care and treatment

The service had evidence it provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

There was evidence to show the service provided care and treatment based on national guidance and evidence-based practice. This was because there were written operating procedures in place. However, the protocols we saw were written in 2019, overdue a review and therefore out of date.

The manager carried out checks to make sure staff followed guidance.

The provider had policies and procedures to show how they protected the rights of patients subject to the Mental Health Act 1983. However, staff members told us they had not received any referrals for patients subject to the Act.

There were policies to support staff to plan and deliver high quality care according to best practice and national guidance.

The service took part in the CQUIN (Commissioning for Quality and Innovation) scheme and provided service quality information to commissioners for their review.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs. The service made adjustments for patients' religious, cultural and other needs.

Patients were given advice about eating and drinking before scans and the service made sure patients who needed to fast were given early appointments to make things easier for them.

Staff gave patients enough to drink to meet their needs. Patients were not at the service long enough to require food to be provided.

Drinks were made available where appropriate to patients attending for diagnostic tests.

Pain relief

Patients did not receive pain relief from staff working at the service because the service did not keep any medication on site.

Care and treatment delivered to patients did not require pain relief.

The registered manager told us there was no medication used at the service. Therefore pain relief was not available to patients.

Requires Improvement

Diagnostic and screening services

Patient outcomes

Staff monitored the effectiveness of care and treatment for patients. There was evidence they made improvements and achieved good outcomes for patients.

Staff monitored the effectiveness of care and treatment. The provider carried out formal assessments of the quality of care and treatment they delivered. Scans were checked to look for discrepancies and feedback given to staff when necessary.

Staff worked together to look at scans if there was any uncertainty about them to make sure they were processed and read correctly.

There was a process for measuring if outcomes for patients were positive, consistent and met expectations, such as national standards and therefore, we were assured that patient outcomes were used to improve patients' experience and quality of care and treatment.

There was a programme of audits to check improvement over time however this had been impacted by the Covid-19 pandemic and audits were less frequent. The provider had plans in place to increase the number of audits in the coming months.

Quality improvement was discussed, checked and monitored at staff meetings.

Competent staff

The service had processes to make sure staff were competent for their roles. Managers appraised staff's work performance and held appraisal meetings with them to provide support and development.

Staff records were held onsite and stored securely. They did not always have complete information about the recruitment process of staff members. For example, files did not contain completed application forms, evidence of qualifications, employment history, interview record forms and references. Therefore, the provider could not demonstrate that they had carried out due diligence when recruiting staff.

The service made sure staff were competent for their roles. There was a process in place to do this.

Managers appraised staff's work performance and held appraisal meetings with them to provide support and development. If staff performance was below standard, this was addressed by the manager.

The registered manager told us staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. It was clear what qualifications and skills were required by the service to deliver patient treatment safely.

There was an induction policy and therefore we were assured managers gave all new clinical staff a full induction tailored to their role before they started work.

Staff who worked at the service had appraisals carried out by leaders at Leeds Screening Centre.

Staff were supported to develop through regular, constructive clinical supervision of their work and continuous professional development at Leeds Screening Centre.

Requires Improvement

Diagnostic and screening services

Staff told us they attended virtual staff meetings. We looked at the minutes of the last three meetings and saw training and professional development were standard agenda items.

The registered manager monitored the training needs of their staff. Most staff who worked for the service also worked as sonographers in NHS trusts and could access training and professional development this way.

Staff had the opportunity to discuss training needs with their line manager at their annual appraisal and were supported when appropriate to develop their skills and knowledge through their role at Leeds Screening Centre.

The registered manager had a process by which to identify poor staff performance promptly and support staff to improve.

Multidisciplinary working

Healthcare professionals worked together as a team to benefit patients. They supported each other to provide care.

Staff worked across health care disciplines when required to care for patients.

Staff did not hold regular multidisciplinary meetings to discuss patients however they did occasionally discuss patients with each other, radiologists and other health professionals when necessary.

We saw staff had referred patients for additional support provided by other services if this was necessary. Staff also communicated with patient GPs and hospital consultants to ensure important information was shared with the relevant interested parties.

Seven-day services

Services were not available seven days a week to support timely patient care.

Leeds Screening Centre provided services by appointment only to patients.

Leeds Screening Centre did not provide seven-day services for their patients, although some services were provided in the evenings and at weekends. Patients needing medical care other than by pre booked appointment accessed the NHS.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff gave general advice to patients about health and wellbeing related to their reason for appointment if required, to support the welfare of the patient. However, this was not the primary function of the service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Patients were supported to make informed decisions about their care and treatment and national guidelines were followed. Patients who lacked capacity to make their own decisions were not seen at this service.

Requires Improvement

Diagnostic and screening services

Staff told us they did not see patients who lacked capacity to consent to treatment however, we were assured staff understood how and when to assess whether a patient had the capacity to make decisions about their care, should the situation arise.

The service used verbal consent and we saw examples of where this was recorded in patient notes.

The service also relied upon implied consent. For example, if a patient offered an arm when being informed that blood needs to be taken, this was classed as implied consent. When we spoke with staff, they told us they explained to patients what would happen and if patients presented themselves ready for the procedure, they classed this as patients giving consent for the procedure.

Are Diagnostic and screening services caring?

Good

We rated caring as good

Compassionate Care

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

Patient survey results for the last 12 months, sent to us by the service showed 187 out of 240 (78%) patients rated their privacy as five out of five. However, three patients commented that they did not feel comfortable because there were no curtains for them to get undressed behind, or a changing room.

Patient survey results for the last 12 months showed 189 of 240 (79%) respondents rated the healthcare professional they saw as five out of five.

The patient survey results also showed 192 of 240 (80%) patients gave four or five out of five for meeting their expectations.

Patients we spoke with told us staff out them at ease and comments within the survey corroborate this.

Emotional Support

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

Patients who responded to the survey commented how happy they were with the support they received, especially when there were complications or anomalies identified.

Patients were given reassurance about test results and supported to access other services when this was necessary.

Requires Improvement

Diagnostic and screening services

We heard staff speaking with patients in a calming way, explaining what was going to happen. Patients we spoke with said they felt relaxed and comfortable during their scans.

Understanding and involvement of patients and those close to them

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

The survey results showed sonographers took time to explain to patients what would happen during their scans. This put patients at ease

Patient survey results from the last 12 months showed 181 of 240 (75%) rated the willingness of the health care professional to answer questions as five out of five.

Comments from patients included in the survey highlighted how happy patients were with how their questions were answered by clinicians and how clinical information was explained to them in language they could understand.

Are Diagnostic and screening services responsive?

Good

We rated responsive 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 others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of patients.

Facilities and premises were appropriate for the services being delivered.

Patients in need of additional support or specialist intervention were referred to the appropriate NHS hospital.

Managers monitored and took action to minimise missed appointments.

Managers ensured that patients who did not attend appointments, were contacted to check their welfare or referred to the original person who referred them for welfare checks to be carried out.

Meeting people's individual needs

The service took account of patients' individual needs but did not always take robust action to make sure they were met. Staff used their own experience to make reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The manager told us the service did not see many patients who had additional support needs and those who did come to the service were supported by a carer.

Requires Improvement

Diagnostic and screening services

There was no policy in place to direct staff how to support patients with additional support needs such as those living with dementia or a learning disability although there was online training available to staff.

The organisation could order interpreters for patients whose first language was not English however, the manager told us they preferred to use an online translation application or family member. We had concerns about the safety of this because there was a risk of information being mistranslated, mistakes being made, wrong information being given to patients or information being wrongly passed on to the patient. This posed a risk to the patient and the unborn child. The use of family members as interpreters is poor practice. We could not be assured the service was accessing interpreters for patients appropriately.

Patients could access chaperones to accompany them whilst they had procedures.

Access and flow

People could access the service when they needed it and received the right care promptly. Staff monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes.

Staff worked to keep the number of cancelled appointments/treatments/operations to a minimum.

If patients had their appointments/treatments cancelled at the last minute the provider worked closely with the patient to arrange a new appointment as soon as possible to make sure there were minimal delays.

Staff referred patients to other services when additional care or treatment was needed.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about the care they received. The manager investigated complaints and these were discussed at team meetings. We saw that complaints were a standing agenda item for team meetings. There was no evidence that patients were included in the investigation of their complaint. The service exercised Duty of Candour.

Information about how to complain was clearly displayed in patient areas and there was a written complaints policy in place for staff or patients to refer to which clearly set out timelines and the responsibilities of the provider.

Leeds Screening Centre had a formal process for people to give feedback or raise concerns about care received other than via social media.

The manager told us the service took concerns and complaints seriously and investigated them. The registered manager handled complaints and they were discussed at the team meetings.

Some patients had raised concerns via social media however negative comments had not been responded to on the same platform. We were therefore unclear about whether the service addressed these concerns.

The organisation had a Duty of Candour policy in place which staff could refer to. We were assured that the correct process would be carried out in the event of an incident that required the formal Duty of Candour process to be followed.

Requires Improvement

Diagnostic and screening services

Are Diagnostic and screening services well-led?

Requires Improvement

We rated well-led as requires improvement.

Leadership

Leaders had the skills and knowledge to run the service. They understood the responsibilities and obligations they had as the provider of regulated activities however the service was not meeting all regulations.

The service was led by the registered manager. They were responsible for the governance of the service and making sure the service was compliant with regulations. Some regulations such as relating to recruitment and infection prevention and control were not being met. Their management of the service was supported by an office manager.

The registered manager demonstrated understanding of their responsibilities in carrying out or managing regulated activities however the service as not meeting all of the standards required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA regulations).

We identified a number of regulation breaches within the service and a number of areas of concern which had not been addressed such as privacy and dignity, infection prevention and control, recruitment processes, safeguarding training and knowledge, robustness of incident reporting, use of interpreters and support for patient with additional needs. These had either not been identified or timely action taken to rectify them.

We requested audits, policies, procedures and protocols, for example, patient outcome audits, safeguarding policy, risk management policy and risk register. These were all provided and the manager understood their importance to the running of the service.

Vision and Strategy

The service had ideas of what it wanted to achieve and develop in the future, working with relevant stakeholders. Leaders and staff understood how to apply their ideas, make plans and monitor their progress.

The service had an ambition to increase the number of patients it saw and there was a plan about how they would do this.

During this inspection, we received assurance the service was complying with most regulations in the Health and Social Care Act 2008.

There was outcome data to show the service provided high quality safe care for patients.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development.

The service had an open culture where patients, their families and staff could raise concerns without fear.

Requires Improvement

Diagnostic and screening services

Governance

Leaders operated effective governance processes throughout the service. There was clarity about the roles and responsibilities of staff at all levels and there were regular opportunities for all staff to meet, discuss and learn from the performance of the service.

We asked for policies, procedures and documentation after inspection and this was provided to us. Most contained the detail necessary to give assurance about implementation of governance processes. However, there were some gaps. There was no policy in place for supporting patients with additional support needs or whose first language was not English.

Service level agreements were in place and these were monitored to make sure the service was delivering services in line with the contracts.

The staff met every three months. We reviewed the minutes of three meetings. Governance was a standing agenda item for every meeting, as was complaints. However, the minutes contained little detail about the actual discussions that took place therefore we were not fully assured that complaints, incidents and quality were discussed in enough detail. Additionally, anyone who could not attend the meeting would not be able to catch up on what they had missed just by reading the minutes.

Management of risk, issues and performance

The provider had systems to manage performance effectively. They identified and escalated patient risks and identified actions to reduce their impact. They had plans to cope with unexpected events.

The provider had identified some of the current risks at the registered location associated with running the service and identified how the service would meet its duty of care to patients and staff however not all potential risks to patient and staff safety had been addressed and action taken to mitigate or remove risks.

There was a risk register in place, and this was reviewed regularly however we were concerned that not all risks had been identified, such as only having one sink for handwashing.

The registered manager used systems to manage performance effectively. They had plans to cope with unexpected events.

The service carried out risk assessments for service users. This made sure service users were not at risk of harm as they received care and treatment that met their needs.

The service monitored and audited patient outcomes post-procedurally. This meant the service compared their performance and clinical effectiveness to other similar services.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were secure. Data or notifications were consistently submitted to external organisations as required.

The service collected and analysed information to understand performance and make decisions and improvements.

At this inspection we identified up-to-date and comprehensive information on all patients' care and treatment.

Requires Improvement

Diagnostic and screening services

Information about patients was shared appropriately with GPs or other clinical services and scans were uploaded to a shared system for radiologists to report.

Clinical records were stored at the location and all staff knew how to access them. We were assured patient information and records were stored safely and securely, in line with the Data Protection Act 2018.

The service could provide leaflets and letters in different languages if this was needed and did this using online translation applications. We had some concerns about this because online translation applications are not always accurate.

Engagement

Leaders and staff encouraged patients to give feedback about the care and treatment they had received in order to make improvements. The organisation collaborated with partner organisations to help plan and deliver improved services for patients.

Patients were encouraged to feed back to the service about their experiences using an online survey. Some patients also left online reviews about the service including complaints, but these were not always responded to.

The service sent us the raw data of the results from the patient questionnaire. We reviewed this and found the results to be positive however we were unclear about how the service used the information it collected, whether it was analysed, by whom or how it was then used to make improvements for patients.

The provider worked with local stakeholders to improve the quality of the services they delivered.

Learning, continuous improvement and innovation

The service was committed to continually innovating services. They had a good understanding of quality improvement. Leaders encouraged innovation.

There was opportunity for staff to continually learn and improve services and the service provided the latest in pregnancy screening tests.

The registered manager demonstrated a good understanding of quality improvement methods and had the skills to use them.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure that infection prevention and control best practice is followed. (Regulation 12(2)) • The provider should make sure bins in clinical areas have pedal opening lids, so waste is enclosed after disposal. • The provider should make sure clinical waste and sharps bins are easily accessible to all applicable staff and located in all clinical areas where they will be used. • The provider should make sure furniture within clinic rooms such as drawers, beds and chairs meet infection prevention and control standards.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The service must ensure staff are able to demonstrate they would recognise possible abuse and be clear about who should be contacted if there is a concern about a person being the victim or at risk of abuse. (Regulation 13)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Requirement notices

The service must ensure systems or processes are established and operated effectively to ensure staff are recruited in full accordance with Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA regulations)(Regulation 19).