Beehive Solutions Limited

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Requires improvement
Are services effective?	
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

Beehive Solutions Limited is the name of the provider, registered location and service. The service provides non-obstetric and vascular ultrasound services to patients aged 17 and over. The service does not operate from fixed clinical premises and carries out procedures under contract from clinical commissioning groups (CCGs) and from rented space in GP practices. This was flexible and at the time of our inspection the service provided clinical services on one half-day per week. Staff use mobile ultrasound equipment, which they maintain and store.

We inspected this service using our comprehensive inspection methodology. Due to the nature of the service, we provided the clinical lead with short notice of our inspection. This was so that we could be sure the service would be operating on the day we inspected. We carried out the inspection on 14 March 2019 and 26 March 2019.

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.

The registered location is the provider's head office and administrative centre. As part of our inspection we observed the service being delivered from a GP practice. The GP practice was not included in our inspection or ratings. We also visited the registered location to be able to speak with staff and obtain evidence for governance and equipment.

An ultrasound receptionist and service manager staff the head office five days a week, which is equipped to receive referrals, confidential patient information, the secure storage of scanned images and post-scan reports.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

We rated the service as **Good** overall.

- 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. Staff assessed risks to patients, acted on them and kept good care records. The service had processes in place to manage safety incidents and to learn lessons from them.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- The clinical lead ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

We found one area of outstanding practice:

- The service was highly responsive and was able to offer same-day, on-demand scans in any region it operated. This provided patients with an urgent need with a significant reduction in waiting times for a scan referral.

Summary of findings

We found areas of practice that require improvement:

- In the GP practice the service was operating out of during our inspection, there was an unshaded skylight directly above the scanning monitor. This provided a sub-optimal view of the scanning screen and needed to be reviewed.
- Staff used probe covers that had expired in August 2016. This meant safety processes were not in place to ensure perishable stock was rotated and disposed of appropriately. After our inspection the registered manager disposed of old stock and obtained new probe covers for subsequent procedures.
- Staff did not always adhere to good infection control practices.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Dr Nigel Acheson
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	We rated this service as good because it was effective, caring, responsive and well-led. There were some areas the service needed to address in relation to patient safety.

Summary of findings

Contents

Good

Beehive Solutions Limited

Services we looked at
Diagnostic imaging

Summary of this inspection

Background to Beehive Solutions Limited

Beehive Solutions Limited is the name of the provider, registered location and service.

The service opened in 2010. It is a service that operates from GP practices under contract from clinical commissioning groups. The service provides diagnostic imaging services across a broad geographic area, including London, Essex and Kent.

The service has had a registered manager since 2011.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a specialist advisor. The inspection team was overseen by Terri Salt, Interim Head of Hospital Inspection.

Information about Beehive Solutions Limited

The service is registered to provide the following regulated activity:

- Diagnostic and screening procedures

To come to our ratings we spoke with the registered manager and an ultrasound assistant. We observed six procedures that were carried out in a GP practice. The GP practice was not part of our inspection. We also spent time at the provider's head office, which was the registered location, to review audits and governance processes and arrangements for equipment storage.

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

One sonographer, two ultrasound assistants, one service manager and one administration manager provided 1.7 whole time equivalent (WTE) cover. Two agency sonographers regularly led clinics. The service manager was the named clinical lead.

Track record:

- No never events
- No clinical incidents, with or without harm
- No serious injuries
- No complaints
- No incidences of service-acquired infections

We last inspected the service in March 2013 and found it to be compliant with the five regulations we inspected. This was the first inspection using our new methodology.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as **Requires improvement** because:

- The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection.
- The design, maintenance and use of facilities, premises and equipment did not always keep people safe.
- The design, maintenance and use of facilities, premises and equipment kept people safe, although was not always optimal for the service provided.
- The service had systems and processes in place to manage patient safety incidents. There were gaps in the recognition of reportable incidents, although staff knew the reporting system well.

However, we also found areas of good practice:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. The clinical lead regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.
- 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.
- The service had systems and processes in place to manage patient safety incidents. Staff recognised reportable incidents and knew the reporting system well. Managers ensured that actions from patient safety alerts were implemented and monitored.
- Staff kept equipment and premises clean.
- Staff managed clinical waste well.

Are services effective?

We do not currently rate effective for diagnostic imaging services.

Summary of this inspection

We found areas of good practice:

- The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and recommended additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. The clinical lead appraised staff's work performance and held supervision meetings with them to provide support and development.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Are services caring?

Good

We rated caring as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Are services responsive?

Good

We rated responsive as **Good** because:

Summary of this inspection

- 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.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment were in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. There was evidence the service treated concerns and complaints seriously and would investigate them and share lessons learned with all staff**.** The service would include patients in the investigation of their complaint.

Are services well-led?

Good

We rated it as **Good** because:

- The clinical lead had the integrity, skills and ability 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. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The clinical lead and staff understood and knew how to apply them and monitor progress.
- 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.
- The clinical lead operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Staff used systems to manage performance effectively. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Summary of this inspection

- 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 integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- The service actively and openly engaged with patients, staff and public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

However, we found areas for improvement:

- Staff had not identified and escalated all relevant risks and issues or identified actions to reduce their impact.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Requires improvement	N/A	Good	Good	Good	Good
Overall	Requires improvement	N/A	Good	Good	Good	Good

Good

Diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Requires improvement

Mandatory training

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

- The service required clinical staff to complete and remain up to date with 21 mandatory training modules, including cardiopulmonary resuscitation (CPR), manual handling, fire awareness, adult and children safeguarding, infection control, conflict resolution, equality and diversity, health and safety and information governance.
- At the time of our inspection all staff were up to date with their training. The clinical lead ensured staff had refresher training at appropriate intervals and provided time for them to complete this. Where staff worked for the service under practising privileges or on a casual basis, the clinical lead ensured they had evidence of training completion before they could provide care.
- Training modules were appropriate to the services provided and to the role of each member staff.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it**.**

- All staff were required to have up to date adult and children safeguarding level 2 training before they were able to practice. This was in line with the Royal College of Nursing intercollegiate document on safeguarding.
- An up to date safeguarding adults and children policy was in place and reflected national best practice. The service had developed the policy with support from an NHS trust to ensure it reflected current standards of practice.
- The clinical lead was the safeguarding and Prevent lead. Prevent is the government's national strategy to identify people at risk of radicalisation. The provider had an established Prevent policy, which included the government's anti-terrorism policy, Channel.
- The provider did not operate its own clinical premises and staff provided services from GP practices. At the time of our inspection this included GP practices outside of the provider's borough. The GP team held details of the local authority safeguarding team, including the urgent crisis team. In a safeguarding situation the sonographer would liaise with the GP practice manager to coordinate a rapid referral and response.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. However, they kept equipment and the premises visibly clean.

- All staff were required to have up to date infection control training before they were able to practice.

Good

Diagnostic imaging

- Staff were not always bare below the elbow and did not always wash their hands prior to patient examinations. Hand-washing after patients was inconsistent and staff washed their hands after only three of the six procedures we observed.
- Although staff were not responsible for the maintenance or upkeep of service premises, they were accountable for infection control processes while providing care. The team carried a stock of antibacterial cleaning equipment and used this appropriately to wipe equipment and the examination bed between patients.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

- Staff provided services from GP surgeries and followed local rules for the use of premises and equipment. They carried some equipment owned by the provider, including scanning equipment and computers for patient referrals and reporting.
- Contracts and service level agreements were in place to ensure equipment was serviced in line with manufacturer recommendations. The provider operated two ultrasound machines, both of which had been serviced within the previous 12 months.
- The provider maintained back-up probes and a back-up laptop to ensure the service would not be delayed or suspended in the event of primary equipment failure.
- In the GP practice the service was operating out of during our inspection, there was an unshaded skylight directly above the scanning monitor. This provided a sub-optimal view of the scanning screen and needed to be reviewed.
- Staff used probe covers that had expired in August 2016. This meant safety processes were not in place to ensure perishable stock was rotated and disposed of appropriately. After our inspection the registered manager disposed of old stock and obtained new probe covers for subsequent procedures.
- Staff used condoms to cover probes for internal exams instead of covers manufactured specifically for this purpose. As condoms are not intended for this purpose, there is a risk they will split or fall off the probe. We discussed this with the registered manager, who promptly obtained appropriate probe covers.
- During our inspection staff did not demonstrate use of a suitable system to track and record probe cleaning. This meant there was not a robust method of ensuring probes were cleaned consistently and of maintaining evidence for this. After our inspection the provider told us they used such a system as standard practice.
- Staff used disposable paper on the examination couch and changed this between each patient. However, in some cases staff changed this when a new patient entered the treatment room. This was not in line with best practice.
- The clinical lead obtained a building layout and plan from GP surgeries in advance of providing services from them. They used this to establish how they could operate safely and efficiently and enabled them to apply generic fire safety and evacuation principles to their plan of work.
- The clinical lead completed a risk assessment for each clinical space they provided services from and completed this to meet the local risk assessed requirements of the practice or location. For example, they provided services out of GP practices, which each had their own clinical and environmental risk assessments. The risk assessment completed by this provider complemented this rather than replaced it.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

- The clinical lead was available on call at all times services were provided and ultrasound staff contacted them in the event of an urgent need for referral. A consultant radiologist provided contracted, on-call services to the provider and was always available by phone when the service was in session.
- Staff saw patients who were medically fit and not at known risk of deterioration. This formed part of the referral criteria so that doctors did not send patients who were unwell or clinically unfit for a scan. However, in the event a patient presented with significant illness or symptoms, the sonographer carried out an initial assessment to determine if it was safe to proceed with the planned procedure.

Good

Diagnostic imaging

- It is national best practice to confirm a patient's identity prior to carrying out a procedure by using three points of identification, such as date of birth and home postcode. During our observations, staff routinely checked only two forms of personal information.
- Staff provided care in the premises of other healthcare providers and followed local procedures for clinical emergencies. For example, they noted the location of emergency resuscitation equipment, such as grab bags and oxygen, before starting a clinic. The provider had established an overarching cardiopulmonary resuscitation (CPR) policy based on the guidance of the UK Resuscitation Council and the 2017 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science with Treatment Recommendations (CoSTR). As part of the policy, all staff had up to date basic life support (BLS) training.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. The clinical lead regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

- One sonographer, two ultrasound assistants, one service manager and one administration manager provided 1.7 whole time equivalent (WTE) cover. Two agency sonographers regularly led clinics. The service manager was the named clinical lead.
- There was a vacancy for one sonographer on a 0.1 WTE basis. In the previous 12 months, one ultrasound assistant had left the service and one individual had joined.
- In addition to agency sonographers, the service had a policy for staff to provide care under practising privileges. This meant the member of staff worked for another organisation substantively and provided services to this organisation under specific terms and within a defined scope.
- The provider had a standardised recruitment and induction process for permanent and agency staff, which ensured each individual underwent the same checks. This included a Disclosure Barring Service (DBS) check, a fitness to work assessment, a review of qualifications and registration and two professional references.
- The registered manager operated a separate sonographer recruitment organisation, which meant they had access to agency staff with a consistent standard of experience and qualifications. The service used NHS frameworks to assess the suitably of prospective new staff as part of an established recruitment process to ensure legal compliance. The service carried out enhanced background checks on sonographers.
- Between August 2018 and October 2018, agency sonographers had provided two shifts. The clinical lead used a robust induction process for agency sonographers that included a check of their competency in using clinical equipment.

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.

- Staff managed records in line with the provider's records management policy. This was based on national best practice guidance in relation to confidentiality and the information governance lead had overall responsibility for this.
- The service manager audited 5% of all examinations performed to review the consistency of request forms, the quality of images and the completeness of the final report.
- We reviewed 12 sets of patients' records and found consistent standards of completion. Each record included legible notes, details of the examination carried out and the clinical justification.
- The registered manager carried out spot-checks on the reports of sonographers who provided occasional services. This was a rolling safety and quality check programme and ensured sonographers produced reports of consistent quality.

Medicines

The service did not store, prescribe or administer medicines.

Incidents

Good

Diagnostic imaging

The service had systems and processes in place to manage patient safety incidents. There were gaps in the recognition of reportable incidents, although staff knew the reporting system well. Managers ensured that actions from patient safety alerts were implemented and monitored.

- The service had an established incident policy. This included guidance on the recognition of an incident and its severity and impact and the reporting procedure. The incident reporting system applied to all staff who provided services on behalf of the provider, regardless of their role or main place of employment. This meant the system was standardised and ensured the senior team had consistent oversight.
- Staff we spoke with had a clear understanding of common reportable incidents and could describe the process for recognising and reporting in detail. However, staff did not have a robust contingency plan in place in the event a condom split during an examination. This event would present a contamination risk. Although staff said they would stop using the probe, send it for examination and inform the patient, staff did not identify this as a reportable incident.
- The service had not documented any incidents in the previous 12 months and so we could not assess the effectiveness of the investigation process in practice. As staff said they would not report incidents such as failure of disposable items, we were not assured the track record was a true picture of safety.
- An incident reporting policy and checklist guidance was in place for reporting serious incidents to the strategic executive information system (STEIS). The incident policy was based on national guidance, including the reporting of injuries, diseases and dangerous occurrences Regulations (RIDDOR) (1995).
- In the previous 12 months the service reported no never events, SIs or incidents with harm.

Are outpatients and diagnostic imaging services effective?

We do not currently rate effective.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

- Policies and protocols were evidence-based on appropriate sources, including the National Institute of Health and Care Excellence (NICE) and the British Medical Ultrasound Society.
- The clinical lead audited ultrasound images and examination reports to identify the accuracy and effectiveness of clinical performance in meeting the initial request of the referring clinician. They reviewed all referrals and the types of scan undertaken planned and undertaken to ensure the service provided was clinically effective.
- An equality impact assessment was in place for each policy and protocol, in line with best practice guidance from the Equality Act (2010). This ensured the service applied standards of care to all patients equally, without discrimination based on protected characteristics.
- The service had an established, rolling audit programme in place to assess and benchmark standards of care. The programme included a clinical audit plan with seven key audits, including patient examination reports, healthcare records and patient safety.
- As part of benchmarking and audit standards, the clinical lead carried out a blind peer review of a sample of each sonographer's scans and reports. They used this process to monitor discrepancies and to identify areas of good practice and for improvement. We reviewed two documented peer reviews and saw the team used them to drive service consistency and improvement.

Pain relief

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

- Staff provided care to patients who were medically stable. This meant they rarely encountered a need for pain relief. Where a patient was known to experience pain during some types of procedure, staff recommended appropriate non-prescription pain relief medicines.

- Staff documented unexpected pain during a procedure in their report, which they sent to the referring clinician. This helped the referrer plan pain relief in advance if further scans were needed.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

- Staff logged each referral request on an electronic system. This included each clinical request and key episodes of care, including when they had completed scans and sent reports. This formed part of a patient outcomes tracker, which the team used to support referring clinicians with care planning.
- The service provided care commissioned by different clinical commissioning groups (CCGs). The clinical lead monitored patient outcomes within these contracts using key performance indicators (KPIs), which they tracked to identify trends over time. For example, between November 2017 and February 2019 the service reported no clinical errors and no rejected scans or discrepancies.
- Processes were in place to respond to discrepancies or errors in reporting. This included a discussion and review of images with the patient's GP following a report, which the sonographer could edit and update based on further review of the information.
- The sonographer prepared a report for the referring doctor immediately after each scan.
- Between July 2018 and October 2018 the clinical outcomes audit identified fully compliant completion of patient records and summary information.
- Between April 2018 and September 2018: Staff sent 100% of routine reports to the referring clinician within three days. This met the service standard. Staff also sent 100% of urgent reports to the referring clinician within 48 hours. This met the service standard.

Competent staff

The service made sure staff were competent for their roles. The clinical lead appraised staff's work performance and held supervision meetings with them to provide support and development.

- The clinical lead was responsible for the application of the staff supervision and appraisal policy. This established the ongoing requirements for all staff, regardless of role and contract type, to undergo regular appraisal and supervision. This ensured a standardised approach was used across all types of staff.
- Appraisals were based on a learning ethos and focused on future training and development opportunities for each individual, this was in addition to a more formal review of performance. The clinical lead used appraisals to review the efficacy of company policies and protocols and encouraged staff to provide constructive feedback and suggestions.
- The clinical lead was registered with the Health and Care Professions Council (HCPC) and had over 40 years' experience in the NHS, including at ultrasound superintendent level. This individual was also the registered manager and lead sonographer and maintained an annual external appraisal.
- The service had a minimum qualification standard for sonographers, which included a diploma or post-graduate certificate in medical ultrasound as well as current NHS experience. The service had established equivalencies for sonographers who qualified outside of the UK and required advanced International English Language Testing System (IELTS) certification.
- All staff completed a provider induction and a local site induction followed by a period of shadowing before they were able to work alone. This was good practice and meant staff delivered care to consistent standards.
- The clinical lead monitored each individual's performance by reviewing the standards of their reports and track record in meeting KPIs along with patient feedback. This was an effective process because it allowed the service to monitor staff who worked for the service sporadically.
- The clinical lead used reflective processes to support staff in their development. For example, they used feedback from patients and stakeholders and outcomes from incidents and complaints to identify areas of good practice and opportunities for positive change.
- Safeguards were in place to ensure staff could only work when they had up to date evidence of competency and performance.
- The service acted on Healthcare Professional Alert Notices (HPANs) issued by NHS Resolution. HPANs are notices that alert providers that a healthcare professional may pose a risk of harm to patients, staff or the public.

Good

Diagnostic imaging

- The clinical lead carried out periodic supervisions with sonographers and healthcare assistants. We reviewed two examples that had taken place in the previous 12 months and saw they were focused on the individual's practice, competency and service they provided to patients. Where staff scored less than the maximum rating for each area of review, the clinical lead provided written feedback on areas for improvement.
- New ultrasound assistants spend a supernumerary period of shadowing to ensure they understood the provider's processes and to demonstrate their competencies before they were able to work with sonographers with their own responsibilities.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

- Referring doctors were able to be present at the time of the scan with the consent of the patient. This enabled the sonographer and GP to work together to address the patient's specific needs.
- The clinical lead had established good working relationships with the GP practices from which they operated. This enabled GPs to make same-day referrals for scanning and worked reciprocally so that the sonographer could request advice from a GP.
- Sonographers were proactive in working with referring clinicians. For example, where they found a need for urgent clinical action, they discussed findings with the referrer immediately and coordinated a care and treatment plan.

Seven-day services

Key services were available seven days a week to support timely patient care.

- The service operated flexibly within commissioning contracts and had capacity to provide clinical sessions seven days a week on demand. This included providing short-notice and same-day scans on request.

Health promotion

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

- Staff typically saw patients on a single occasion for appointments that lasted up to 20 minutes and were not involved in long-term, holistic care planning. However, the team was proactive in offering opportunistic health promotion information and advice when appropriate. For example, they signposted to local non-profit and specialist services such as smoking cessation and for weight loss.

Consent and Mental Capacity Act

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

- All staff maintained Mental Capacity Act (MCA) 2005 and Mental Health Act (MHA) 2007 training.
- An up to date consent policy was in place and staff adhered to this whenever they provided care. The policy reflected best practice standards from the General Medical Council (GMC) and included obtaining consent from carers and for procedures on patients under 18 years old. We observed the consent process in practice and saw staff used it consistently and appropriately. Consent processes were in line with best practice guidance from the The Royal College of Obstetricians and Gynaecologists (RCOG) 2015.
- Staff obtained verbal consent for non-invasive processes and documented written consent for more invasive procedures, including for trans-vaginal and trans-rectal ultrasounds or where a needle insertion was necessary.

Are outpatients and diagnostic imaging 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.

- We observed staff treat patients with kindness, dignity and respect. They took the time to provide care with empathy and friendliness and made sure patients were relaxed and at ease before a scan.

Good

Diagnostic imaging

- Staff completed training in delivering care with compassion and empathy as part of the provider's mandatory requirements.
- At the end of each examination, staff were required to ask every patient for feedback on the procedure. This was part of the provider's approach to ensuring the understood the patient experience on a rolling basis.
- The clinical lead used staff appraisals and clinical supervisions to review how staff delivered care with compassion and kindness. They used examples of good practice with the team in meetings and worked with individual staff members to improve their approach, where this was needed.
- As part of their agreement with commissioners, the service supplied each patient with an anonymous feedback form. This measured specific areas of satisfaction and enabled the clinical lead to quantify feedback. Patients rated the service consistently well. For example, between January 2018 and August 2018 the service achieved a 98% satisfaction rating and 95% of patients rated the service overall as 'excellent.'

Emotional support

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

- Staff provided patients with information leaflets and written information to explain their scan. This included straightforward explanations of the type of scan they were due to have and what the scan would produce.
- Staff discussed treatment options with patients and encouraged them to actively participate in the decision-making process.
- We observed staff provide gentle reassurance to patients who were nervous or anxious and take extra time to explain the process. Staff extended this approach to anyone accompanying the patient, including relatives.
- Staff understood how to ensure patients privacy and dignity if they became distressed, including during procedures and when they were waiting to be seen.

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.

- Staff ensured patients understood the service was independent from their referring GP when they called patients ahead of the appointment and during the consent process. This helped patients to understand the differences between organisations and professionals involved in their care.
- Staff told patients the process for the report after their scan, including a timeframe for their GP to receive the report and contact them.
- Staff provided patients with a copy of their report on request, and a copy was sent to their GP if they had been referred by another clinician.
- Care was usually planned in advance on an elective basis. This meant staff knew in advance if patients had specific communication support needs. Where GPs referred patients with communication needs for a same-day urgent appointment, the services worked together to ensure they could meet this.
- Sonographers ensured patients knew who to contact if they had queries or concerns following their scan, and prior to their referring clinician contacting them.

Are outpatients and diagnostic imaging 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.

- The service worked across multiple clinical commissioning group (CCG) areas and adapted services to meet local needs. The provider offered pre-booked lists on scheduled days. The provider provided a responsive service and visited GPs on request to carry out urgent or ad-hoc scans. This avoided the need for

patients to join lengthy waiting lists at hospital. GPs used this service for patients who would find it difficult to travel to hospital or who might have had to wait for long periods of time for a scan.

- The clinical head had established a collaborative approach to service delivery and improvement. This meant the team delivered the service responsively by acting on feedback from patients and stakeholders. This provided the opportunity for the provider to address gaps in the service and identify opportunities for improvement.
- The service was proactive in identifying wider opportunities for improvement. For example, where the service found local systems involving multiple providers could be improved or streamlined, they proposed changes with other providers and commissioners.
- Staff were enthusiastic and positive about trialling changes to provider a better patient-centred service. The clinical lead encouraged staff to discuss ideas for improvements and supported them to establish plans to test feasibility.
- The service did not operate from its own dedicated premises and provided care from GP practices. As such the service could not guarantee local facilities in advance. During our inspection we saw the GP reception team greeting patients for the diagnostic imaging service and providing clear instructions for accessing the service. Staff met patients and collected them from the waiting area and escorted them to the clinical room.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

- Staff worked with patients to arrange appointments and access to suit their individual needs. For example, if patients needed to starve prior to a scan, staff booked an early morning appointment to make the starve period more comfortable. Where patients had school-age children, staff worked with them to schedule appointments that did not interfere with the drop-off or pick-up time of their child at school.
- Referring clinicians advised the service if patients were using NHS transport and the clinical lead coordinated this to ensure it was arranged to meet appointment attendance times.
- The dedicated administration officer included a printed copy of a local map and a photograph of the clinic location with each appointment letter. This helped patients unfamiliar with the local area find the clinic and reduced the risk of an associated delay.
- Staff arranged for an interpreter to be present during the appointment if needed and had the facility to send out appointment letters in languages other than English.
- Staff worked with the referring doctor to maintain contact with patients after a scan. For example, staff said patients often did not answer calls, text messages, or e-mails for several days after a scan. Where there was a need for a follow-up scan, the lead sonographer spoke with the referring doctor who contacted the patient.
- It was common practice to carry out scans without warming up the gel beforehand. This was not in line with standard practice, which includes using warm gel because it reduces discomfort for the patient.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment were in line with national standards.

- GPs referred patients to the service as an alternative to the hospital outpatients department. The provider offered short-notice appointments as well as advanced bookings up to two weeks in advance. The service accepted referrals by e-mail through secure NHS e-mail addresses, by fax, and through the national e-Referral service (ERS). The sonographer leading a list on any given day accepted same-day referrals from GPs within the surgery for patients with an urgent need.
- The provider booked a room in the GP surgery for a full day, which enabled them to offer additional capacity on the day if needed.
- The clinical lead managed referrals centrally to ensure coordination of appointments and staffing was consistent. They contacted each patient the day before their appointment as a reminder and to reconfirm the time.

Good

Diagnostic imaging

- The service had a reliable track record and had not cancelled any appointments or lists between March 2017 and March 2019.
- A dedicated administration officer booked appointments in line with the availability of sonographers with specialist training and competencies.
- The patient was contacted by telephone to arrange a suitable appointment. If not possible to reach the patient by telephone, an email and/or letter was sent to the patient to request that they contact the provider to make an appointment.
- The service operated flexibly and arranged extended or additional lists where an appointment delay would result in a breach of the referral to treatment time (RTT).
- The clinical lead maintained waiting lists at less than two weeks by providing staff levels and clinic appointments responsively and flexibly. Each clinical list had empty slots until the day prior to the clinic to help facilitate access for urgent referrals.
- Between April 2018 and September 2018, 71% of patients were seen within 10 days of an initial routine referral. As an overall average, this did not meet the standard of 75%. However, the service met or exceeded the standard in three months during this period. In the same period, 100% of patients were seen within three weeks of the initial routine referral, which met the service standard.
- Between April 2018 and September 2018:
  - 84% of patients were seen within five days of an initial urgent referral. This was better than the service standard of 75%.
  - 100% of patients were seen within two weeks of an initial urgent referral. This met the service standard of 100%.
- The service worked to a target of no more than 5% for patients who did not attend (DNA) a booked appointment. Between April 2018 and September 2018, 10% of patients did not attend their appointment. This was significantly worse than the target and reflected a monthly range of between 6% and 19%.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. There was evidence the service treated concerns and complaints seriously and would investigate them and share lessons learned with all staff**.** The service would include patients in the investigation of their complaint.

- A complaints process was in place and all staff were trained to engage with patients who wished to make a complaint. The administrator included a printed copy of the complaints process with each appointment letter. The complaints process was displayed in the clinical rooms the service operated from.
- The complaints policy was based on a range of national best practice guidance, including that issued by the NHS and the Parliamentary and Health Service Ombudsman. The policy included a detailed flowchart for the investigation of complaints and communication with the complainant. The policy was risk-based and designed to help staff identify the potential risk of a similar issue and complaint recurring in the future.
- In the 12 months leading to our inspection the service had received no formal complaints. This meant we could not review the complaints investigation and learning processes in practice. The track record reflected the approach of staff, who aimed to resolve minor issues and concerns before they became the subject of a formal complaint. The clinical lead was available by phone at all times when the service was in operation, and discussed any issues with patients at the time they occurred. Staff kept patients informed on the day of their appointment if the list was delayed, which could occur if another patient's scan took longer than planned. This approach ensured patients remained informed and reduced the likelihood of a complaint.
- All staff were trained to respond to complaints, both verbal and written, and understood how to learn from these for service improvement. Training included how to assist patients or relatives to document a complaint so that it could be investigated and addressed.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as **good.**

Leadership

The clinical lead had the integrity, skills and ability 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. They supported staff to develop their skills and take on more senior roles.

- The clinical lead acted as the registered manager and service manager, and was the main point of contact for all staff, patients and stakeholders. A company director was in post but was not part of the day-to-day delivery of the service. They supported governance and finance functions of the organisation.
- The service manager was responsible for quality assurance processes and had embedded these into all aspects of the service to support staff to achieve them.
- Staff spoke highly of the service manager and said they had opportunities for progression and development. The service manager had implemented appropriate systems to ensure staff had access to immediate support and escalation during clinical lists.
- The clinical lead visited the GP practices from which the service operated on a monthly basis to meet GPs and practice mangers to review systems of work.
- The service manager maintained positive working relationships and partnerships with GP practices, clinical commissioning groups (CCG) and other stakeholders. This helped to drive service continuity and sustainability and contributed to a consistent standard of care.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The clinical lead and staff understood and knew how to apply them and monitor progress.

- The service was focused on sustainability and future development and was actively working with stakeholders and commissioners in this area. The clinical lead had implemented a strategy to raise awareness of the service and to promote the potential benefits for patients. This included sharing appropriate key performance indicator data and anonymous patient feedback.
- The clinical lead worked with sonographers who worked primarily for other providers to develop the future direction of the organisation through better understanding of local population demands and the local health economy.

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.

- The clinical lead held monthly staff meetings and ensured staff who worked part-time or occasionally for the service attended. We reviewed the minutes of each meeting held from March 2018 to August 2018 and found meetings were typically well attended and appropriately structured. Staff used the meetings to discuss service issues, performance, training and other areas essential to good organisational culture and performance. Where staff raised issues there was a demonstrable focus from colleagues and the senior team to address these quickly.
- Meeting minutes demonstrated a culture of open discussion and feedback facilitated by the clinical lead.

Governance

The clinical lead operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

- The clinical lead and company director were responsible for governance and quality monitoring. An established clinical governance framework was in place and enabled the senior team to coordinate information governance and staffing and to control policies and protocols. The policy was robust and fit for purpose and the senior team had reviewed this at appropriate intervals.
- The provider contracted a compliance service that identified in advance when training or professional checks were due to expire for any individual working

with the service. This formed part of the overarching clinical governance framework to ensure the service was operated safely and in line with established standards and targets.

- The clinical lead worked with each GP practice or location they operated from to implement specific local work rules and governance standards. This ensured staff adhered to the provider's own clinical governance and health and safety policies as well as those of the service they were operating from. We reviewed two such examples and found they were up to date and fit for purpose.
- The provider was not required to maintain annual quality accounts as it did not meet the minimum thresholds for financial turnover or number of employees. However, the senior team recognised the benefits of annual quality reviews and audits and maintained equivalent processes as good practice.

Managing risks, issues and performance

Staff used systems to manage performance effectively. They had not identified and escalated all relevant risks and issues or identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

- An up to date clinical governance and risk policy was in place and had been updated regularly. The policy acted as a framework to minimise risks to patients and to the service by establishing local rules of work.
- The clinical lead was responsible for managing risks to the service. The primary risk was sustainability if the service did not maintain a continuous throughput of patients. The senior team had recently increased marketing to address this and had secured a new contract with a CCG to begin providing services, which would begin imminently.
- There was a lack of assurance about risk management in relation to the use of condoms to cover probes instead of specific probe covers. This reflected the lack of consideration the team had given to managing some risks associated with the practice.
- The provider had established an emergency business continuity plan (EBCP) for use in unforeseen circumstances that could interrupt the service. This was based on several best-practice standards for business continuity management and supply chain recovery and reflected the specific nature of the service. For example, the clinical lead had a clear understanding of their responsibilities under the Civil Contingencies Act (2004), which applied to providers delivering services on behalf of other organisations.
- As part of the EBCP, processes were in place to protect data and the operation of the service if the head office became uninhabitable. All data, patient information and policies were available remotely and the senior team had equipment that would enable them to maintain the service remotely.
- Appropriate performance and contract monitoring processes were in place with CCGs that commissioned services. This process ensured services were provided in line with local need and to a consistent standard. The clinical lead monitored key performance indicators in line with CCG requirements.

Managing information

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

- An overarching information governance management framework was in place and incorporated information security assurance and data risk management.
- Data management processes protected against loss or breach. Staff worked remotely in GP surgeries and stored all data from scans, including notes and reports, on an encrypted hard drive. Staff kept equipment with them and did not leave any equipment capable of storing data in the GP surgery.
- The senior team had developed a detailed risk assessment register for all aspects of information and data management. This reflected international best practice and adhered to the requirements of the General Data Protection Regulations (GDPR) 2016/679 and the Data Protection Act (2018). For example, the team had risk assessed each item of equipment used to process or record data, such as external hard drives. The team had implemented appropriate mitigation strategies for each

risk, including for differences in processes when working between different locations. The information governance lead was the accountable person for each risk.

Engagement

The service actively and openly engaged with patients, staff and public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

- The service was guided by the large volume of patient feedback received. Staff used this feedback to help understand areas of good performance and identify opportunities for improvement. The clinical lead mapped anonymous feedback to the sonographers leading each session to understand how individual clinicians delivered the service. The service also acted on feedback relating to the GP practices they operated from. For example, patients commented that one GP surgery did not offer fresh drinking water. The clinical lead worked with the GP practice manager to provide this when the service was operating.
- The service had acted on feedback from patients that found it time-consuming to one GP practice by establishing a relationship with a service in a more convenient location.
- The clinical lead worked actively with CCGs and healthcare providers to develop and expand the service.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

- Staff understood that the service relied on its ability to respond to changes in patient demand and on the ability to identify gaps in service provision in local health economies. The clinical lead was proactive in identifying opportunities for expansion and proactively approached CCGs and GP practices to discuss service development. This had resulted in a new clinic in east Essex in late 2018. The new clinic had reduced patients travelling times and reduced waiting times in the local area.

Outstanding practice and areas for improvement

Outstanding practice

- The service was highly responsive and was able to offer same-day, on-demand scans in any region it operated. This provided patients with an urgent need with a significant reduction in waiting times for a scan referral.

Areas for improvement

Action the provider SHOULD take to improve

- Staff should ensure they have an unobstructed view of essential scanning equipment at all times during procedures.
- Staff should implement robust stock control measures to ensure disposable equipment is only used when within its useful date as set by the manufacturer.
- Staff should use disposable equipment for its intended purpose only and ensure the equipment used for each procedure is appropriate.
- Staff should adhere to the national standard of a three-stage ID process prior to carrying out each procedure.
- The provider should ensure staff are consistent in infection prevention and control standards.
- Staff should review their understanding of reportable incidents and ensure this is aligned to patient safety.

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.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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