Harmonic Medical Sonography Limited

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Inspection report

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

Ratings

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

Summary of findings

Overall summary

We rated this location as requires improvement because:

- The service did not always provide mandatory training in key skills to all staff or make sure everyone completed it.
- Not all staff had completed training on how to recognise abuse and systems for delivering and ensuring this was in place were not always clear.
- The service did not always control infection risk well. The service did not manage clinical waste safely at the time of inspection.
- The provider did not monitor or have oversight of when ultrasound machines had last been serviced.
- The service did not always check to make sure policies were regularly reviewed. The service did not always collect outcome data or monitor the effectiveness of care. Records were not always stored securely.
- It was not always easy for staff to find information on how to raise a concern. The service had no whistleblowing policy in place at the time of inspection.
- Governance systems were unclear and there was a lack of corporate oversight in management of issues and risks across the service.

However:

- 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 service held regular CPD meetings to keep staff up to date with best practice and national guidance.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Requires Improvement 	

Summary of findings

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Summary of this inspection

Background to Harmonic Medical Sonography Limited

Harmonic Medical Sonography Limited is a registered location for Harmonic Medical Sonography Limited. The registered manager had been in post since the location had been registered in April 2020. The location is registered to provide the regulated activity of diagnostic and screening procedures. The service provides diagnostic ultrasound procedures on a sessional basis at a range of GP and healthcare locations. The registered location hosts a clinic on site for private patients and is the provider's main administrative base for the delivery of services, which are mainly at sites in Staffordshire and East Sussex.

We have not previously inspected this location.

How we carried out this inspection

We carried out a comprehensive inspection to assess the provider's compliance with fundamental standards of safety and quality. We looked at key questions of the safe, effective, caring, responsive and well-led domains.

Two inspectors carried out the inspection with off-site support from an inspection manager and head of hospital inspection.

We reviewed specific documentation, interviewed key members of staff including the registered manager; sonographers, and the senior management team who were responsible for leadership and oversight of the service. We also spoke with 10 patients about their experience of treatment and care as a service user.

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

Areas for improvement

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

Action the service MUST take to improve:

- The provider must ensure that equipment is maintained and serviced in accordance with manufacturer's guidelines. Regulation 12 (1)(2)(d)
- The provider must have processes in place to ensure that staff are suitably qualified, competent, skilled and experienced to provide a safe service. Regulation 12 (2)(c).
- The service must ensure that clear and accessible information is provided for patients regarding how to raise any concerns or complaint. Regulation 16 (1).
- The provider must ensure that their audit and governance systems remain effective. Regulation 17
- The service must review their policies for relevance to the service context and ensure review dates are appropriately identified. Regulation 17(1)(a).

Summary of this inspection

- The service must ensure there are effective systems and processes to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Regulation 17 (1)(a).
- The service must maintain secure records in respect of each service user. Regulation 17 (2)(c).
- The service must ensure that recruitment procedures are followed according to service policy and to meet the requirements of Schedule 3 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 19 (2)

Action the service SHOULD take to improve:

- The provider should develop a chaperone policy in line with best practice.
- The service should ensure that local safeguarding protocols and escalation processes are reviewed and continue to provide staff with the relevant levels of safeguarding training.
- The service should review and take action to improve systems for identifying and meeting the individual needs of patients, including any disabilities, sensory disabilities or language needs patents may have.
- The service should ensure that training for Learning Disability and Autism awareness is mandatory for all staff.
- From 1 July 2022, all CQC-registered health and social care providers have to make sure their staff receive training on learning disabilities and autism appropriate to their role, under s181 of Health and Care Act 2022.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Diagnostic and screening services

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

Is the service safe?

Requires Improvement

We rated it as requires improvement.

Mandatory training

Staff did not always have up to date mandatory training in key skills.

Staff had received mandatory training, but this was not always up to date. The service did not have any Learning Disability and Autism awareness training in place for staff which became mandatory from 1 July 2022 under the Health and Care Act 2022.

During the inspection we reviewed records which confirmed that staff training was out of date. Out of the 8 staff mandatory training records we received on post inspection only 2 staff were up to date. Only 2 out of 8 staff had up to date mandatory training in modules such as basic life support. Expired mandatory training certificates ranged from March 2021 to December 2021.

At the time of inspection, the service had no system in place to monitor or alert staff when training had expired, however following our inspection, the service had developed a training matrix table which monitored and recorded when their current mandatory training expired.

Following the inspection, we were provided with evidence that staff had undergone the relevant mandatory training modules.

Safeguarding

Not all staff had completed training on how to recognise abuse and systems for training delivery and ensuring this was in place were not always clear.

Staff received training specific for their role on how to recognise and report abuse, however this training was out of date for 6 out of 8 staff mandatory training records we reviewed.

The service had a safeguarding children policy which recommended training to level 3 for sonographers, records we reviewed showed staff were only trained to level 1 and 2.

The policy also referenced "Safeguarding Leads must be trained to a minimum of level 3, with evidence of working towards Level 4." however records we reviewed showed the safeguarding lead's training was out of date and had only been trained in levels 1 and 2.

The business development director was the safeguarding lead for the service, they knew how to identify adults and children at risk of, or suffering and significant harm. However, in conversation with us they could not reference how to make a safeguarding referral and who to inform if they had concerns. The private clinic at the service location had a safeguarding poster reminding staff how to report abuse, however the phone number referenced on the poster was for a different local authority.

There was a lack of clarity amongst staff regarding who was the designating safeguarding lead for the service, staff thought the clinical director was the lead.

Safeguarding policies were not effective, they did not include contact details for local authority safeguarding teams. The safeguarding children policy was incomplete, referencing appendices that were not part of the document and polices that did not exist at the time of inspection such as a chaperone policy.

The service did not have a chaperone policy, patients were advised on booking to bring someone along with them who could act as a chaperone, this was not in line with best practice guidance.

Following the inspection, we were provided with evidence that sonographers and the safeguarding lead had undertaken level 3 safeguarding training for adults and children.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. However, premises were visibly clean.

Methods for cleaning transvaginal transducers in the Ultrasound Probe Decontamination Policy were different to the methods outlined in the Transvaginal Probe Cleaning Procedure. It was unclear after reading the two what methods should be adopted when cleaning the transducers.

The design of the clinic room at the registered location meant it could not be cleaned effectively, the carpet flooring and fabric chairs were not impermeable to dirt and liquid.

Wipes and PPE such as masks we found at the service were out of date by November 2021 and May 2022 respectively. Curtains had not been replaced since December 2021.

There was no documented evidence that clinical staff had undertaken the appropriate cleaning of the ultrasound equipment. We saw no evidence of infection control audits.

The room cleaning records outlined what should be cleaned and cleaning frequencies. General cleaning records were up-to-date and demonstrated that areas were cleaned regularly.

The overall environment and equipment throughout the clinic were also visibly clean and well-maintained.

Following the inspection, the provider told us they had discarded the Transvaginal Probe Cleaning Procedure to avoid confusion.

Environment and equipment

The service did not always ensure specialist equipment was maintained and did not always manage clinical waste well.

The service did not dispose of clinical waste safely. At the time of inspection there was no appropriate clinical waste bag in place for disposal of probe covers. The service did not have a clinical waste removal contract in place.

We saw evidence of environmental risk assessments that covered lighting, uneven floorings, ventilation, equipment check and washing facilities. However, the review date was December 2021, therefore out of date at the time of this inspection.

The provider did not monitor or have oversight of when ultrasound machines had last been serviced. This meant there was a lack of assurance around the performance of the scanning machines. 3 of the 5 ultrasound machines were last serviced in December 2021, therefore not in line with maintenance requirements of every 12 months.

Premises at the registered location were accessible, with plenty of parking nearby. On the ground floor there were toilet facilities, and water dispenser for visitors. The clinic itself was accessible by a lift and was situated on the first floor, it comprised of one office which was used by management and admin staff and a separate private clinic room. The clinic room was only accessible via the office. Two of the office computer screens could be seen on route to the private ultrasound room, this posed a risk to a breach of patient confidentiality.

The clinic room contained a desk, fabric chair, treatment couch, ultrasound machine, a sink and a lockable storage area. Staff had access to supply of stock consumables, including PPE however this was not always in date. There was no specific patient waiting area patients and staff informed us they would usually wait downstairs in the lobby prior to their appointment.

We saw evidence the electrical equipment, including the ultrasound scanning machine had up-to-date portable appliance testing (PAT) stickers on. We saw evidence of the fire extinguisher check which was current at the time of inspection. The service had completed fire safety checks for their own environment. We saw a fire risk assessment for the building, but this was dated February 2020.

The service had its own first aid kit stored in office adjacent to the clinic room. We saw evidence of a basic life support sequence poster that referenced the use of an automated defibrillator; however, at the time of inspection the service did not have one.

Following the inspection, the service provided us with evidence that they now had a fire risk assessment in place dated February 2023. The provider also told us they had moved computers screens to face away from the pathway to the clinic.

Since the inspection the provider supplied us with evidence to show they now have a clinical waste contract in place.

The service also provided evidence after the inspection that they had serviced the 2 ultrasound machines that were previously out of date.

Requires Improvement

Diagnostic and screening services

Assessing and responding to patient risk

Staff knew how to identify and act upon patients at risk of deterioration Staff completed risk assessments to remove and minimise risks

The service conducted generic environmental risk assessments which identified risks of slips trips and falls. The service did not identify any specific risk assessments that would be completed for each patient following their referral, sonographers would risk assess patients based on their clinical judgement.

We saw evidence on 8 out of 10 imagining reports where staff had documented whether service users had any allergies such as latex.

The sonographers worked as lone workers, and at the time of inspection the service did not have a lone working policy in place, however this was included as part of the general risk assessments.

Sonographers completed an initial vetting of referrals for accepting to the service, with any inappropriate referrals returned to the GP as required. The service had an exclusion criterion for NHS referrals this included; ultrasound guided procedures, obstetric care, breast, cardiac imaging, chest, ophthalmology, thyroid, children under the age of 18 and non-NHS service users. The service had a separate exclusion criteria for private patients which included; ultrasound guided procedures and obstetrics scans 12 weeks and over.

We saw evidence of an urgent findings pathway policy which contained a flowchart demonstrating how reports could be urgently escalated to clinicians.

Staff knew how to respond to a deteriorating patient but did not always have the up to date training, 6 out of 8 staff were overdue in basic life support modules.

Following the inspection, we were provided with evidence that staff had undergone the relevant mandatory training modules, this included basic life support modules.

Staffing

The service had enough staff with the right qualifications, skills, and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

At the time of inspection there were 4 sonographers including the registered manager. The service had just recruited another sonographer who was currently on induction. The service did not use agency staff at the time of this inspection.

The administration and management team were based at the service headquarters. There were 4 patient administrators, a lead administrator, a managing director, clinical director, business development director and a business operations manager. The service had a clinical director who at the time of inspection was working 3 days per week, their main focus was on quality assurance and audits.

Requires Improvement

Diagnostic and screening services

The service had a recruitment selection policy in place which included a list of requirements prior to recruitment. This included evidence of CV, right to work in the UK, Disclosure and Barring Service (DBS) checks, work health assessments, references, evidence of qualifications, and confirmation of registration with a professional body where this applied. From our observations on inspection this guidance was not always followed, DBS checks were not always in place, and we saw gaps when it came to work health assessments.

Leaders made sure staff had a full induction of the service. The induction for clinical staff comprised of three months job shadowing and monthly appraisals.

Following the inspection, we were provided with evidence that the service had enhanced DBS checks in place for all sonographers.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, and easily available to all staff providing care. However, we noted that records were not always stored securely

The service had been primarily paperless since 2019. Referrals to the service were received from GPs and made via a secure digital system. Sonographers vetted referrals, any not accepted would be returned to the GPs.

The service had a contract for an imaging archiving storage system. Scan images did not automatically transfer from the ultrasound machines to the imaging storage system. Images were stored on a USB hard drive and later transferred by the registered manager at month end. Images could be uploaded on the same day for urgent findings by the sonographers. All images and data were backed up.

All service policies were stored on an intranet, all members of the team had access to this.

Records were not always stored securely. During our inspection we found an unlocked cupboard containing patient consent forms, this posed a risk to a breach of patient confidentiality.

On inspection we saw evidence of an information commissioner's office certificate that had expired in October 2022; therefore, the service was not always up to date with methods and processes to manage data safely and securely.

Following the inspection, the service provided us with an up to date ICO certificate.

Since the inspection provider told us they had shredded the old patient consent forms kept in the cupboard, and were no longer storing physical documents containing patient data

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff met during team meetings to discuss feedback, discrepancies and look at improvements to patient care.

Requires Improvement

Diagnostic and screening services

The service had an adverse incident reporting policy in place however it contained sections that were not relevant to this service such as MRI and ionising radiation. The policy referenced an information governance manager, however at the time of inspection there was nobody of that role in the service.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff raised concerns and reported incidents in line with the service's policy.

Managers shared learning about discrepancies with their staff at regular meetings.

Is the service effective?

Inspected but not rated

We inspected but do not rate the domain for effective.

Evidence-based care and treatment

The service did not always check to make sure policies were regularly reviewed. However, managers checked to make sure staff followed guidance based on evidence-based practice.

At the time of inspection staff informed us that they were in the process of updating their service policies, nevertheless we saw number policies that had review dates of 2020. We noted that there were sometimes two versions of the same policies available for staff to access, both had different review dates, meaning there was a risk of staff accessing the older version.

The service did not have a policy review schedule in place to ensure they regularly reviewed and updated policies. This meant that the service may not be following the most up to date guidance.

Some of the policies content did not appear to be relevant to the service. For example, the consent policy referenced seeking consent for anaesthesia and blood transfusions. The cleaning, disinfection and sterilisation policy referenced information for cleaning morgues and laboratories. We noted some of the policies we reviewed also made reference to other policies that did not exist at the time of this inspection; for instances the safeguarding children policy referenced; disciplinary policy and patients' rights policy, none of these were included in the policy list provided to us by the service at post inspection.

We saw evidence that the service conducted audits on imaging quality, however this did not seem to be on a regular basis with August 2022 being the most recent audit.

The service held regular CPD meetings to keep staff up to date with best practice and national guidance.

Following the inspection, the service also provided evidence that they had carried out internal imaging quality audits from September to December 2022.

Nutrition and hydration

Requires Improvement

Diagnostic and screening services

Staff ensured patients had drunk enough water when needed prior to their investigation. Patients could access drinking water at local clinic facilities.

Patients told us that preparation instructions for scans were clear. Patients were given instructions over the phone at booking and this information was followed up by text.

Patient outcomes

The service did not always monitor the effectiveness of care.

The service was subject to a range of key performance indicators agreed between the provider and the local clinical commissioning groups for the satellite clinics.

The service had a monitoring system in the office from which they could monitor and review waiting times at the different locations.

Records confirmed the service held monthly staff meetings to discuss image quality, any discrepancies and complaints received by the service.

We asked the service to provide us with any recent audits, the most recent supplied was dated August 2022. The audits that we saw were conducted by an external company who reviewed a 5% sample of images, however we were told by leaders that service was no longer using that external company and insisted they were conducting their own internal audits, yet we saw no recent evidence of this.

Competent staff

Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, the service did not always ensure staff were up to date with relevant skills and knowledge needed for their roles.

The registered manager supported staff to develop through yearly appraisals of their work, identified any training needs for staff to develop their skills and knowledge. All staff had received an annual appraisal.

Managers gave all new staff a full induction tailored to their role before they started work. Leaders told us new sonographers would undergo a 3-month shadowing period where they were classed as supernumerary and had monthly appraisals with the registered manager.

We saw evidence of monthly CPD meetings where staff were given updates to changes to practice and kept updated with scanning techniques and sonographic appearances relating to different pathologies. Leaders made sure staff attended team meetings or had access to full notes when they could not attend.

Staff were experienced, qualified, but did not always have the right skills and knowledge to meet the needs of patients. Most staff were overdue mandatory training modules at the time of inspection.

Multidisciplinary working

Requires Improvement

Diagnostic and screening services

Doctors, nurses and sonographers worked together as a team to benefit patients. They supported each other to provide good care.

The service had key relationships with GPs who made referrals to the service, and other professionals at the host healthcare clinic premises.

Seven-day services

Key services were available to support timely patient care.

Services were mostly available Monday to Friday across different clinic locations. In some service locations, clinics were available on weekends, dependent on local facilities and contractual agreements.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

The service had an up to date consent policy in place. However, it was not clear from the policy what processes should be followed to record consent, processes were different to those outlined in the Probe Decontamination Policy which referenced a "Written as well as verbal consent is recommended as a gold standard." However, at the time of inspection staff were only asked for verbal consent from patients.

The consent policy was not specific to the service, detailing a range of procedures that were not relevant, such as; x-rays, surgical procedures and blood transfusions. The consent policy made no reference to transvaginal ultrasound consent processes. Staff told us told us that verbal consent for transvaginal scans would be gained at the time of the scan and that no written consent was taken at any stage.

We reviewed 10 patient ultrasound reports, 9 referenced verbal consent had been received.

Training for mental capacity was included as part of safeguarding level 1 and 2, however this training was out of date for most staff at the time of this inspection.

Is the service caring?

Good

We rated it as good.

Compassionate care

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

Requires Improvement

Diagnostic and screening services

Staff were responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

All 10 of the patients we spoke to said staff treated them well and with kindness. Patients said staff introduced themselves and took the time to explain what the scan would involve.

Staff understood and respected the personal, cultural and social needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients. They understood patients' personal, and cultural needs.

Patients felt staff were able to provide them with help, emotional support and advice when they needed it. Patients felt staff were approachable and answered any questions they had.

Staff supported patients who to maintain their privacy and dignity. Staff followed policy to keep patient care and treatment confidential. Patients felt staff were very understanding and professional.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported patients to understand their condition and make decisions about their care and treatment.

Staff took the time to explain what the scan involved and were clear about how to access results following the appointment. Staff made sure patients and those close to them understood their care and treatment.

Patients felt supported by staff to make informed decisions about their care. Patients felt staff talked in a way that they could understand. Staff were unable to tell us if there was any specialist support for patients who required communication aids.

All 10 of the patients we spoke to post inspection gave positive feedback about the service, they felt staff were friendly and appreciated the timeliness of booking appointments. However, all patients we called said it was not clear how they could share this feedback with the service.

Is the service responsive?

Requires Improvement

We rated it as requires improvement.

Service delivery to meet the needs of local people

Requires Improvement

Diagnostic and screening services

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 provided at different locations, hosted within GP and healthcare clinic facilities, to provide local access and ensure the required staff were available for NHS patients. These facilities and premises were appropriate for the services being delivered.

The service locations we reviewed were easily accessible by public transport and had free parking available on onsite.

Managers ensured that patients who did not attend appointments were followed up by phone call to rearrange. The service monitored and took action to minimise missed appointments.

Leaders planned and organised services, so they met the changing needs of the local population.

Meeting people's individual needs

The service did not always make reasonable adjustments to help patients access services.

The service had a specific equality and diversity policy. Staff had relevant equality diversity training, but this was out of date for most staff at the time of this inspection.

The service did not have a chaperone policy in place at the time of this inspection. The service advised patients to bring friends and relatives if they wanted a chaperone, this is not always suitable to all patients.

We were told by staff that the service did not provide leaflets or information on their website in other languages spoken by the local community. The service had no specific translation policy or service contract in place at the time of this inspection. Staff told us they would often use patient family members to explain procedures and obtain consent, this is not in line with best practice.

The service did not have facilities to meet the needs of people with sight or hearing problems.

There was no hearing loop and no information available in accessible formats.

The doorways in the private clinic based at the headquarter were not always wide enough to accommodate wheelchair users. However, the ultrasound bed in the clinic was adjustable and could be lowered if patients needed some assistance to manoeuvre onto the bed safely.

Following the inspection, the service provided us with evidence that staff had undergone equality and diversity training.

Access and flow

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

Managers worked to keep the number of cancelled appointments to a minimum. When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible.

Requires Improvement

Diagnostic and screening services

Managers monitored waiting times and made sure patients could access services when needed and received treatment within the agreed 15-day timeframe. Patients had a choice of appointments.

Managers worked to keep the number of cancelled appointments to a minimum. Admin staff work to rearrange appointments as soon as possible.

Learning from complaints and concerns

The service did not always monitor complaints effectively, it was not easy for people to give feedback and raise concerns about care received.

The service had a complaints policy in place. Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service.

Leaders told us they were involved in friends and family feedback tests for NHS clinic. Private patients are sent follow up information to provide feedback about the service. The business operations director analysed this information; positive feedback is circulated amongst staff and any complaints are discussed at staff meetings.

The service website had a "your experience" and "complaints" section for service users to leave their feedback. The website quoted positive reviews the company had received but the most recent was from 2017.

Patients we spoke to did not know how to complain or provide feedback to the service.

The service did not inform people that they could raise their concerns with the Independent Sector Complaints Adjudication Service (ISCAS) if they were not happy with the response they received from the service.

The provider told us post inspection they had a "Your Guide to making Comments and Complaints" in place, however at time of inspection it was not visibly noticeable on the noticeboard. Following the inspection, the service had amended their complaints policy to reference patients to ISCAS.

Is the service well-led?

Requires Improvement

We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They supported staff to develop their skills. They were visible and approachable in the service for staff. They did not always understand and manage the priorities and issues the service faced.

The registered manager was also the managing director for the service and had been in place since the service was set up. The registered manager also works as a sonographer for the service. Their main responsibility was to provide

oversight of service as well as managing governance, conducting clinical meetings, providing clinical support to other sonographers, offering CPD resources and in charge of appraisals for the clinical staff in the service. However, the registered manager did not have a professional annual appraisal in place for himself. The registered manager was away whilst we were conducting the onsite inspection, it was not clear who was deputising in their place.

The registered manager told us they kept up to date with new guidelines and reviewed the British Medical Ultrasound Society's website for updated information. The registered manager was seeking to further their own learning and research and admitted this might mean be less present in the company in the future.

The service had an organisational structure, with a clinical director, business development director, business operations director and lead administrative who were mostly based at the service headquarters.

The service had a new clinical director, who had been in place since September 2022. The clinical director was remote working 3 days a week for the service and practised as sonographer for the NHS for the remaining days. The clinical director's main role was to act as clinical lead for the organisation, supporting clinical team, conducting clinical audits and reviewing patient feedback and complaints. We noticed a significant gap in the number of audits the service was conducting. Prior to September 2022 the company had been using an external company to conduct monthly imaging quality audits. We asked the provider to supply us with the most recent audits, the most up to date was August 2022. We saw no evidence of any infection control audits taking place in the service.

Staff told us they felt management were approachable and easily accessible and had regular appraisals. Staff we spoke to felt supported in their development and spoke about having the opportunity to attend sonography conferences.

Following the inspection, the service provided evidence of internal imaging quality audits from September to December 2022.

Vision and Strategy

The service had a vision for what it wanted to achieve but did not have a clear strategy to turn it into action. Leaders and staff understood and knew how to apply them

Leaders and staff told us patient focus was a central aim of the service, with a plan to extend services, and seek new contracts in the future. Leaders told us their focus was to provide a high quality, accurate, safe and easily accessible diagnostic and screening service.

The service had a set of values which included a vision statement which was "to help build healthier lives".

The service provided us with a set of objectives which included; "To simplify patient care pathway by providing easily accessible, flexible, high quality, accurate, safe and user friendly diagnostic scanning and screening service. To deliver a patient centred service using state of the art scanning facilities, complimented by highly experienced practitioners and accurate clinical reporting and advice. To support our national healthcare services by providing a reliable, safe, caring and effective diagnostic ultrasound scanning service". However, it was not clear how these values would be actioned, and what strategies the service had in place to achieve this, the service did not monitor patient feedback and we saw gaps when it came to clinical audits such as imaging quality.

Requires Improvement

Diagnostic and screening services

The registered manager told they were planning to become an affiliated training facility in tandem with certified training providers. They felt this could be an area growth for the service and enable them to employ those staff thereafter once qualified.

Service leaders told us they frequently engaged with staff and involved them in future service planning and shared with them their vision for the service. Staff were aware of plans for the business to grow and take on more contracts in the future.

Following the inspection, the service provided details of a business plan however this was dated 2014.

Culture

Staff felt respected, supported and valued. The service had an open culture where staff could raise concerns without fear.

Staff we spoke to felt supported and valued by the service and management team. Staff we spoke with said they had opportunities for development, including attendance to relevant conferences. Staff stated managers regularly met with staff, both in groups and individual meetings. Staff worked collaboratively and had pride in working for the service. Staff recommended this service as a place to work to others.

Staff we spoke to felt comfortable raising concerns to senior managers. We were told that staff had the opportunity to raise any issues during team meetings. The service had a complaints policy in place, but this did not include any information about how staff can raise concerns.

The service did not have a specific whistleblowing policy or speak up guardian in place at the time of this inspection.

Following the inspection, the service provided us with evidence they had a whistleblowing policy.

Governance

Leaders did not operate effective and governance processes, throughout the service. Policies and procedures were not reflective of the services provided. However, staff had regular opportunities to meet, discuss and learn from the service.

We saw during the inspection that recruitment procedures were not always followed according to the service's policy. This did not meet the requirements of Schedule 3 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service held monthly governance meetings. The governance meetings had variable content and did not always follow a standardised agenda. The meeting minutes did not always identify who was responsible for the actions to be completed, there were not always indications of timescales for completion and we saw no further evidence of these being reviewed as completed.

The service held monthly staff meetings. Meeting minutes had no fixed agenda but would often involve discussions of key areas of the service, including clinic details, feedback from recent complaints, clinical issues and service updates.

Some policies content did not appear to be relevant to the service. During our onsite inspection we saw staff were making amendments to policy documents, they told us they were updating the service policies.

We saw no evidence of audits for infection control or consent processes. There was a significant gap in the imaging quality audits with the most recent conducted in August 2022.

Management of risk, issues and performance

Leaders had systems in place to manage performance. They identified and escalated relevant risks and issues but did not always identify actions to reduce their impact, there was an overall lack of corporate oversight in risk management.

The service used a risk register to mitigate and monitor risks had been identified but not been reviewed or updated since September 2018. However, post inspection the service reviewed and updated the risk register.

The registered manager told us the main risks for the service were; losing sonography staff, data breaches, and natural disasters. These risks were not referenced in the risk assessments or registers. Losing staff was the primary risk to the service, the service did not have replacements on hand, although we were told they sometimes use bank staff to mitigate this and were in the process of recruiting more staff.

The service did not have a lone workers policy in place at the time of this inspection, but we did see evidence that lone working had been risk assessed.

We were provided with evidence an employer liability insurance certificate that was in date.

Information Management

The service collected reliable data but did not always analyse to understand performance. The information systems were not always secure.

The service had system in place to monitor appointment and waiting times for the different locations. The service provided routine monthly reports to NHS commissioners to demonstrate outcomes against key performance indicators (KPIs), the registered manager explained they had struggled to meet targets in August 2022 and September 2022 due to sonographer vacancies but had seen improvement in recent months. The registered manager told us they had a KPI of five days turn around which they are currently meeting within two days.

We did not see any evidence that the service was using the data it collected to improve or analyse performance.

The service used a third-party contractor to back-up and store data.

The service had a data protection policy had been reviewed in September 2022 and policy referred to the NHS Digital Records Management Code of Practice for data retention and destruction time frames.

On inspection we saw evidence of an information commissioner's office certificate that had expired in October 2022.

During the inspection we found copies of historic patient consent forms that were stored in an unlocked cupboard.

Requires Improvement

Diagnostic and screening services

The provider told us post inspection that patient consent forms had been appropriately disposed of and were no longer storing any physical documents containing patient data on site.

Engagement

Leaders and staff actively engaged with patients and staff to plan and manage services.

Staff told us they frequently asked patients for their feedback, this information would be collated and analysed by the business operations director. However, most patients we spoke to were not aware of how they could provide feedback about the service.

Staff meetings were held monthly to review, improve and share service updates. Meeting notes showed discussions were taking place to ensure the service and staff were maintaining good standards.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

Staff engaged in regular meetings to discuss discrepancies and any recent complaints or feedback. We saw evidence of regular CPD meetings.

However, at the time of inspection the service did not carry regular audits to drive service improvements or performance data to enable change or improve practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider did not ensure that information was clear and accessible for service users to make a complaint.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The service did not ensure that recruitment procedures were followed according to service policy and to meet the requirements of Schedule 3 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective governance processes to ensure they were able to assess, monitor and improve the quality and safety of the service. The provider did not maintain securely records in respect of service users.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

The provider did not have processes in place to ensure that staff were suitably qualified, competent, skilled and experienced to provide a safe service.

The provider did not ensure the equipment used for providing care were safe for use.