Mediscan Diagnostic Services Ltd

Mediscan Diagnostic Services Limited

Inspection report

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

Ratings

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

Summary of findings

Overall summary

Our rating of this location improved. We rated it as requires improvement:

- 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 had implemented systems to manage safety. The service had introduced systems and processes to improve control of infection risk. Staff kept care records. The service had implemented systems for managing safety incidents and learned lessons from them.
- Managers had systems for monitoring the effectiveness of the service and made sure staff were competent.
- The service made it easy for people to give feedback about treatment and care
- Leaders ran services using information systems and supported staff to develop their skills. Staff felt respected, supported and valued. Staff were clear about their roles and accountabilities.

However:

- Patient risk assessments were not always clearly identified and documented. We saw some ultrasound equipment units remained onsite which had not been identified in current maintenance servicing contracts. There was a lack of consistency in quality assurance checks for ultrasound equipment. There was a lack of contingency plans in the event of equipment failure at satellite locations.
- Audit processes for safeguarding, IPC and equipment checking had been identified but not yet embedded due to limited clinical activities at the time of inspection.
- Wider service risks were not always clearly considered or identified in risk registers and there was some duplication between the quality improvement action plan and the risk register.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Requires Improvement 	Our rating of this location improved. We rated it as requires improvement .See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Mediscan Diagnostic Services Limited

Mediscan Diagnostic Services Limited is operated by Mediscan Diagnostics Services Ltd. The location has been registered to deliver diagnostic and screening procedure services since June 2013. The location, which is also the provider's head office, is the call and administrative and managerial centre from which the provider's national diagnostic imaging services are managed.

The provider delivers a range of services including ultrasound scanning, some audiology services and physiotherapy which are regulated by CQC. Following the inspection in June 2021 we imposed conditions on the provider's registration which limited the practice of invasive ultrasound procedures, including endoscopy, colonoscopy, sigmoidoscopy and trans- vaginal scans.

The location does not host any clinics on site, the clinics are provided in GP surgeries, private clinic buildings and hospitals, Mediscan Diagnostics services ran between 99 and 130 satellite locations from these sites. Between April and November 2021, we have carried out four inspections.

We last inspected the service in November 2021 and rated it as Inadequate. In the last report, the service breached regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were:

- Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

Following the last inspection in November 2021 we issued Warning Notices for failure to comply with the requirements of Regulation 12 Safe Care and Treatment and Regulation 17 Good governance. This inspection reviewed the provider's actions to improve following the breaches of regulation identified at the last inspection.

How we carried out this inspection

We carried out an unannounced focused inspection of the diagnostic and screening core service on the 8 and 9 March 2022. During our inspection we visited the main location and a satellite clinic at Ashton under Lyne. At the time of inspection, following the period of suspension, the service was beginning to provide appointments for private patients only and had seen three private patients to date.

We inspected to follow up the concerns identified with safe care and treatment and good governance during the last inspection, and to assess the provider's compliance following the Warning Notices issued for regulations 12 and 17.

We looked at parts of the safe, effective and well led domains..

We reviewed specific documentation and interviewed key members of staff including a healthcare assistant, nursing staff, and the senior management team who were responsible for leadership and oversight of the service.

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.

Summary of this 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 SHOULD take to improve:

- The service should ensure that all patient risk assessments are clearly identified and documented and onward referral pathways for private patients are clear.
- The service should ensure that all ultrasound equipment units intended for continuing use in the service are included in current maintenance servicing contracts.
- The service should ensure there is a consistent approach in quality assurance checks for ultrasound equipment.
- The service should ensure there are clear contingency plans in the event of equipment failure at satellite locations.
- The service should continue to embed audit processes for safeguarding, IPC and equipment checks.
- The service should continue to implement clear systems for managing risks, issues and performance in the service.

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	Not inspected	Insufficient evidence to rate	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Inspected but not rated	Not inspected	Insufficient evidence to rate	Requires Improvement	Requires Improvement

Requires Improvement

Diagnostic and screening services

Safe	Requires Improvement
Effective	Inspected but not rated
Responsive	Insufficient evidence to rate
Well-led	Requires Improvement

Are Diagnostic and screening services safe?

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

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

Staff received and kept up to date with their mandatory training. Since the last inspection in November 2021, staff had completed updated training in key skills, in both face-to-face sessions and E- learning packages. This had included Mental Capacity Act training; infection prevention and control; basic life support skills; moving and handling; data protection; information governance; and fire, health and safety training. The service had identified a training matrix which showed all staff were up-to date with their mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff received email reminders regarding completion of mandatory training.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it. Processes had been improved to support the appropriate and timely referral of safeguarding concerns.

Since the last inspection in November 2021, staff had completed updated safeguarding training which included children and adults' safeguarding level three for clinical staff; and children and adults safeguarding levels one and two for non-clinical staff. Staff were able to describe the different types of concerns which may present in service as a safeguarding issue. Also, staff had completed scenario training with the safeguarding lead to provide them with a greater awareness of safeguarding issues. We reviewed service documents and related staff records to confirm the safeguarding sessions that had been attended by all staff.

The safeguarding lead role was continuing to be provided by a consultant who had worked with the provider to support continued improvements since the last inspection in November 2021. The consultant worked flexibly week to week, being onsite in the service for a minimum of a day a week, and accessible by email otherwise during working hours.

The provider had updated their safeguarding policy to replace previously separate and different versions, identifying one single Safeguarding Adults policy, dated December 2021. The policy referenced relevant sources, including the Royal College of General Practitioners (RCGP) - Adult Safeguarding Toolkit and the British Medical Association (BMA) - Adult Safeguarding Toolkit. The policy included a safeguarding flowchart, identifying clear process and contacts within the service, where staff had identified any safeguarding concerns. The policy also included details of emergency contacts in local authorities, based on the previous locations where Mediscan services had been delivered. The contact details for Oldham, Kent and Medway Local authority safeguarding services had been updated since the last inspection.

The audit schedule identified safeguarding audits which would be completed when the service resumed any clinical activities. At the time of inspection, the service had only just begun seeing private patients, with three patients seen in the service to date; there had been no safeguarding concerns identified from these.

Cleanliness, infection control and hygiene

The service continued to improve systems and processes to manage infection prevention and control. Staff followed control measures and kept equipment and the premises visibly clean.

Office and clinical areas were clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were mostly up-to-date and demonstrated that all areas were cleaned regularly. Staff in the service continued to complete infection prevention and control (IPC) cleaning checklists for different parts of the service, undertaking spot checks as part of their ongoing process for managing infection prevention and control. These included environmental cleaning checks and equipment cleaning. Although there had only been limited clinical activity in the service, routine cleaning procedures and checks were still being continued. We saw weekly cleaning records for the Ashton satellite clinic were documented as completed a Monday; some of these also had incomplete checks on other days. We saw at the Ashton site there were no records kept for regular tap running/ flushing; however, we also saw Legionella testing certificate completed in August 2021. With only one or two minor exceptions where individual dates had not been completed, we saw completed checklists were kept up to date.

At the Ashton clinic location, we saw a five-litre bottle of ultrasound gel with an expiry date of December 2023. This could be used for refilling individual bottles, presenting a possible risk of transmission of infection.

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

The infection and control lead role continued to be provided by a consultant who had been working to support the service in its improvement work since the last inspection in November 2021. The service had identified a daily environmental risk assessment and all staff had completed IPC training and updates. The IPC lead had introduced IPC competencies for all clinical staff which were not yet fully audited, due to the very limited clinical activities in the service, following the suspension in 2021, and warning notices issued the last inspection in November 2021. IPC audits were identified as part of the ongoing audit schedule in the service. The IPC lead had also carried out scenario work with staff and desktop exercises in relation to infection prevention and control.

The service had identified a decontamination policy which provided details of specialist equipment cleaning, including ultrasound equipment and probes. This policy was based on guidance from the British Medical Ultrasound Society and the Society of Radiographers. We saw there were blank proformas for ultrasound equipment cleaning however we did

not see any completed documents for this. When we spoke to staff, they described procedures for cleaning transducer probes, using antiseptic wipes after removing ultrasound gel. When asked, staff provided varying responses and did not consistently describe what type of covers were used for transducer head probes during intimate diagnostic investigations.

The registered manager told us they were considering buying a decontamination unit for the Ashton site, but there were no immediate plans for this at the time of inspection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use equipment.

Following the last inspection, in response to the warning notice, the service had provided evidence of an annual service contract with an external contractor, from December 2021 to December 2022. This was regarding six ultrasound machines, which we reviewed on site and saw the records were correct with regards to the service contract. We also saw there were a further 18 portable ultrasound units stored in a side room adjacent to the office where the six ultrasound units were kept. When we asked, the registered manager said these machines were being sold privately. During the inspection we also visited the Ashton satellite clinic where there were two large static ultrasound machines. The 18 portable units and the two static ultrasound machines were not identified in any current maintenance servicing contracts we reviewed.

The registered manager had informed us at a previous inspection that the quality assurance of ultrasound equipment was not being completed whilst the service was suspended. On this inspection, we saw records of quality assurance checks that had been completed between 12 and 14 December 2021, with engineer's preventative maintenance checks completed on 17 and 24 January. There were no handover forms following the engineers visit. We also saw QA checks had been completed on 31 January 2022, 2 March 2022, and 7 March 2022. These dates correlated with the dates when private patients had been seen in the service. We noted the QA checks had been done by the registered manager and a sonographer, but the related forms had been completed by the HCA.

During our inspection, in discussion with the registered manager, they confirmed that the ultrasound equipment QA checks were completed by the sonographers when in use in the clinic, however since there were no patients in the service there had not been any quality assurance checks completed. We observed there was no regular routine pattern of ultrasound QA testing programmed for the six ultrasound machines, with no numeric records of the baseline value or gain value to indicate how these values may have changed in the equipment units.

The policy for the quality assurance process indicated that audits would be completed quarterly; we saw these were included on the audit schedule for the service but had not yet been completed, due to the lack of clinical service activity. We observed there remained a lack of clear contingency plans for any equipment failure at satellite locations, in preparation for services resuming.

We saw records to confirm portable appliance testing has been completed for 30 unspecified items, during August 2021.

Assessing and responding to patient risk

There was some improvement in the systems and processes in place for the appropriate and timely referral, triage and escalation of patient care. There were some improvements in completion of risk assessments for patients and staff during care and treatment, but these had not always been considered and mitigating actions identified.

Requires Improvement

Diagnostic and screening services

Following the last inspection, the service had updated their Policy for Justifying Medical Examination by Ultrasound, identifying within this a clear flowchart and triage process for referrals. All referrals would be made via secure NHS email, available for designated clinicians in the service, through password protected access to the NHS portal. In total three clinical staff were identified as responsible for undertaking triage, with the registered manager who was a consultant radiologist, being the lead for triage. In the absence of the registered manager, this would be delegated to the two other clinicians alternately. Referrals would be allocated by the operations manager or office location lead, for booking arrangements. At the time of inspection, the registered manager told us the two senior sonographers who would be involved in completing triage were currently engaged in other locum work, pending the resumption of clinical services at Mediscan. During this time, these staff were also continuing to be employed by Mediscan.

A contract was now in place for a picture archiving and communication system (PACS), commencing from December 2021. The records management policy had been updated to clarify details of the process for transferring images, including details of the PACS process. This was a cloud-based system, with a local server at the main office, for data storage. In the event of any failure of the local server, patient data could be retrieved from the cloud-based system. At the time of our inspection, PACS was only operational on one computer in the management offices; due to office reorganisation and rerouting of cabling. Remote sites and satellite locations have PACS link connection through the Internet; this could be connected to the ultrasound machine and images uploaded to the cloud. Images would also remain on the local ultrasound machine until they were manually deleted, or the machine storage was full. The PACS system provided the mechanism for urgent transfer of ultrasound images in case this was needed. The PACS lead in the service was in the process of identifying user guides and information to share with staff about use of the PACS system; were intended to be included as part of staff induction training.

Staff completed initial risk assessments for each patient on booking and sonographers reviewed this at time of patient attendance. The service had seen three private patients since the last inspection and following the suspension being lapsed, all of whom had self-referred to the service. Two of these patients had consented to have their reports sent to their GP. In both cases further follow-up referral had been suggested, one for urologist, and another for review following previous surgery. The third patient had no disease process reported following their scan. Procedures were unclear in the service regarding what further actions would be followed up to ensure the patient's pathway is being appropriately managed. This would particularly be important in the event of the patient not giving consent for reports to be shared with their GP, or in the case of the sonographer have detected any untoward findings from the scan. Guidance from the British Medical Ultrasound Society states "if self-referrals are accepted by the department or provider, the circumstances when this may occur should be recorded within the local requesting protocols." We did not see any clarification of this process in the providers policies.

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.

At the time of inspection, the service was not providing any regular clinical activity, having only recently resumed appointments, with three private patients being seen to date. There were a total of 12 staff who continued to be employed in the service, including the registered manager, two sonographers, three HCAs, consultancy staff, managers and administrative staff.

Records

Records were stored securely and easily available to all staff providing care.

Requires Improvement

Diagnostic and screening services

The service had updated their records management/health records policy, dated December 2021. The policy referenced nationally accepted guidance including NHS England records management code of practice and the information Commissioner's office (ICO) code of practice. The policy had been updated to include further details about the PACS system and process for image transfer. Records audits were included in the audit schedule however none had been completed since the last inspection in November 2021.

Patient records were electronic, including consent documentation. The consent form for transvaginal scans was due to be fully incorporated into the electronic patient record in April 2022, together with an update to the standard operating procedure for satellite clinics for this.

The service had identified a clinical discrepancy meeting as a desktop exercise, this was for review of scan accuracy and quality. At the time of inspection this was not fully implemented across the service due to the lack of clinical activity. However, plans were in place for this to be continued as a regular process for the future. Staff had also been trained in general administrative checks of scans, following a prescribed checklist.

Incidents

The service had improved processes for managing patient safety incidents. Staff recognised incidents and near misses and used systems for reporting these. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Following the last inspection all staff had completed training in complaints, incidents and significant events and were aware of how to report incidents in the service. The incident and complaints manager had completed training in incident investigation and was identified as the responsible lead. The serious and untoward incident policy had been updated to include incident monitoring and an incident audit was included in the audit schedule.

Staff raised concerns and reported incidents and near misses in line with the service's policy. Staff reported incidents on the services incident and complaints form. The incident and complaints manager reviewed all reports of incidents or complaints, logging these recording these separately in an incident log and/or a complaints log.

Managers reviewed all incidents and complaints at weekly management meetings and monthly governance meetings. Information about any incidents and shared learning was fed back to staff at weekly team meetings.

The service had a duty of candour policy and staff understood the duty of candour. The complaints lead would provide support for individual staff with duty of candour procedures on an individual basis as needed. Staff understood the principles of being open and transparent when engaging with patients and their families, and the need to give patients and families a full explanation if and when things went wrong. At the time of inspection, there were no incidents relating to duty of candour processes, due to the lack of clinical activity.

Are Diagnostic and screening services effective?

Inspected but not rated

We do not currently rate the effective domain for diagnostic imaging services.

Requires Improvement

Diagnostic and screening services

Evidence Based Care and Treatment

The service provided care and treatment based on national guidance and evidence-based practice. Improvements were continuing to quality assurance processes and the service was beginning to implement an audit schedule.

Staff had access to relevant policies and procedures via the service intranet system, with paper documents of key policies also available at the satellite location we inspected. We did not see evidence of electronic or paper access to policies for staff in satellite clinics during our inspection as the service was suspended.

There had been continuing work to review and update service policies and procedures to align these to the processes operated in the service. Since the last inspection the service had identified systems for the ongoing review and update of policies.

Competent staff

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.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. We reviewed three staff files, including one for a member of staff who had been recruited since the latest inspection in November 2021. There was evidence of appropriate checks, registration documents, pre-employment checks including application form, DBS, two employment references, and GDPR consent form, and contract of employment in each folder. The service had a contract in place with two national staffing agencies through which all staff would have the appropriate recruitment checks prior to working in the service. At the time of inspection there were no agency staff planned to work in the service, however it was intended that agency staff would complete the service induction process.

Staff followed the recruitment and selection policy. Managers gave all new staff a full induction tailored to their role before they started work. The induction policy outlined a two-stage induction process which applied to all staff, clinical and non-clinical. The list was comprehensive for mandatory training requirements including, basic life support skills, infection prevention and control, safeguarding training mental capacity act, sepsis training. Stage one incorporated a general introduction to the service and team, with stage two based on learning and supervision completed over a four-week period. The registered manager completed sign off for the staff induction when the staff member was deemed competent

Managers supported staff to develop through yearly, constructive appraisals of their work. Since the last inspection, all clinical staff had completed a competency assessment for their role, including performance monitoring. All service leads had been allocated new training sessions specifically for their roles, with actions being completed for this by April 2022.

Managers made sure staff received any specialist training for their role. The CEO and registered manager had oversight of clinical supervision for the sonographers and HCA's in the service, completing this on a quarterly basis. Specific competency assessment had been identified for sonographers and HCA's. The assessment tool had different competency levels; sonographers would be observed carrying out examinations, including competencies for patient care, working safely, ultrasound machine and equipment, clinical scanning, report writing, and underpinning knowledge.

Requires Improvement

Diagnostic and screening services

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff we spoke with said they attended weekly team meetings and documents we reviewed confirmed their attendance. During any leave staff received email minutes of meetings. In day-to-day working relationships, we observed there were regular frequent communications across the service, and staff were generally aware of the overall service activity in practice.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Are Diagnostic and screening services responsive?

Insufficient evidence to rate

Our rating of responsive did not change as we did not look at enough key lines of enquiry to re-rate the domain.

Learning from complaints and concerns

There was a process for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. Information was also available on the provider's website about how to contact the service to raise a complaint or concern.

Staff understood the policy on complaints and knew how to handle them. The service had undertaken a variety of desktop exercises in how to respond to complaints, and staff we spoke with had a good understanding of what would be considered as a complaint. Staff were able to give examples of complaints that had been received in the service.

Managers investigated complaints and identified themes from complaints. Prior to the inspection we had contacted the service to share details from individuals who had contacted CQC after being unable to contact the service. The service had followed up each of these individual enquiries to resolve the concerns appropriately. During the inspection we were told by service managers that there had previously been an issue with the phone contact lines which was being resolved.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Processes were in place for managers to share feedback from complaints with staff. There were standing agenda items for review and monitoring of complaints at weekly management meetings and monthly board meetings. There was limited evidence of completed complaints investigations lessons learnt due to the recent suspension at the time of our inspection.

Requires Improvement

Diagnostic and screening services

Are Diagnostic and screening services well-led?

Requires Improvement

Our rating of well led improved. We rated it as requires improvement

Leadership

Leaders mostly had the skills and abilities to run the service. The service was continuing to receive significant support from external agencies to fulfil leadership roles. Processes were being established to ensure sustained long-term effective leadership capacity and capability to assess, monitor and improve the quality and safety of services provided. 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.

Following the last inspection, the compliance and quality manager had continued to support service leaders in developing relevant systems and processes for improving the quality and safety of the services provided. The compliance and quality manager was employed by the service through contractual arrangements with an external agency, which had specialist experience in regulatory compliance and the Health and Social Care Act 2008. The compliance and quality manager reported directly to the CEO for the service and was working three days a week in this role. At the time of inspection, this contract was continuing until December 2022. The CEO informed us they were in negotiation with the external agency for continuing long-term engagement for the future. There had been a delay in establishing the role of deputy CEO due to unforeseen absence of key personnel, but this was also planned for in the future.

The human resources manager, safeguarding and infection prevention and control leads continued to work in their roles through contract agreements with external agencies. These contracts were also in place until January 2023. The human resources manager had identified a deputy for their role and was in the process of upskilling this staff member for their related HR activities and responsibilities.

The safeguarding lead had a dual responsibility, also acting as the infection prevention and control lead for the service. The lead had overseen staff training for safeguarding and infection prevention and control, including online learning, scenario discussions and desktop exercises. They worked three days a week for the service, on a flexible basis, with a minimum of one day per week on site. The safeguarding lead received safeguarding supervision externally every six months, as part of their ongoing professional requirements.

All staff had completed safeguarding level three children and adults training, with safeguarding competency checks being planned for staff to complete every six months. The safeguarding lead was in the process of identifying staff from within the service who could be supported to develop into the roles of safeguarding lead and infection prevention and control lead. The safeguarding lead was also beginning to informally support the identified staff for their potential development into these roles for the future.

Since the last inspection, staff with management responsibilities had completed further training in relation to their roles. We saw that the complaints and incidents manager had now completed training in incidents investigation, and relevant staff had completed training in appraising staff performance. Equal opportunities training for managers had been planned but this had been cancelled due to COVID 19; there were rescheduled plans for this to be completed later in March 2022.

Requires Improvement

Diagnostic and screening services

At the time of inspection, following the period of suspension and previous inadequate rating, the service did not have current contracts in place with NHS commissioners. The CEO told us there were continuing discussions about possible areas of service contracts however there were no confirmed details of these, except for one contract directly between the consultant radiologist and a local NHS provider, as part of waiting list initiative. Two other sonographers who were still employed in the service were currently working flexibly in locum contracts whilst the service did not have ongoing clinical activity. The CEO informed us there were still 12 members of staff employed in the service, including the sonographers, HCA's, administrative and management staff.

The service had identified clear procedures for resuming contracted services, in readiness for any potential commissioning agreements. This included a mobilisation plan for community-based ultrasound services at satellite locations, incorporating key areas such as legal aspects; premises and equipment; information management and technology risk assessments and checklists. The service had identified a model for staffing satellite clinics with one sonographer and a healthcare assistant providing services, with a local area business development manager for management oversight and support to the teams at local and regional satellite clinics. Implementation plans would be dependent on the locations confirmed by commissioning contracts.

Since the last inspection the provider had cancelled their registration for surgical procedures and was now focusing on ultrasound as their key service specialism. Leaders were aware of the challenges to the service and had identified key aspects of these in their business continuity policy.

At the last inspection we saw that a comprehensive DBS checking process had been introduced, including a DBS risk assessment form and checklist document. From our review of the personnel files for staff, board members, and directors we saw there was appropriate documentation in place. In particular, we reviewed the details of qualifications, references, recruitment processes and DBS checks for board members and directors to meet fit and proper persons requirements.

Culture

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

In the most recent inspections, it had been identified the service needed to improve the diversity of the organisation. To date there had been little further progress in this area, although managers had been scheduled to complete equal opportunities training. However, due to COVID-19 and staff sickness, this needed to be cancelled. There were plans for this to be rescheduled in March 2022.

Staff we spoke with felt valued and supported in their roles and there was generally a feeling of positivity shared between staff about the improvement work that had progressed since the last inspection.

We saw information displayed on staff noticeboards with contact details for NHS England whistleblowing helpline. The Freedom to Speak up Guardian role was continuing to be provided by one of the consultants from an external agency. There remained some lack of clarity as to how this role was going to be continued for the future by staff in the service, or how relevant information about the freedom to speak up process was available to staff at satellite locations. Similarly, the whistleblowing policy stated that whistleblowing concerns would be investigated by the operations and complaints managers. It remained unclear as to how independently any concerns would be followed up, should these concerns be related to either of these roles.

Requires Improvement

Diagnostic and screening services

Governance

Leaders had identified governance processes which were being established throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from policies and monitoring processes.

Since the last inspection the service had identified a new governance structure, with related systems and processes becoming established. There was a schedule of regular meetings at both operational and strategic levels of the organisation, involving attendance of relevant staff who held different responsibilities. There was a monthly board meeting and monthly governance meeting, with weekly management meetings and a monthly meeting for the whole staff team. Each of the scheduled meetings had standardised agenda items which indicated the identified leads for the related report. The weekly management meeting agenda items included departmental updates; business development and operational delivery; and CQC updates. The monthly governance meeting agenda items included policies and procedures, audits and safety alerts; staffing; ICT, PACS, and equipment quality assurance. From our review of meeting minutes, we saw that all the scheduled meetings included discussions about significant events and learning, including incidents, safeguarding and complaints.

Leaders could clearly articulate the reporting process for the effective flow of information from staff level to the board. Staff we spoke with were clear about their roles and responsibilities, speaking confidently about how they received information regarding service performance and any related issues. Staff could easily access key service policies and documentation via the service intranet and showed clear understanding of the systems that were being embedded.

The service identified an audit schedule which referenced key policies and timescales for related audits. The service had identified clear processes for continuing audit review to inform updates to any policies. This included discussion and revision of any changes at management meetings, and process for sign off at board meetings. At the time of the inspection we saw all policies that we reviewed were in date, relevant for their content, and clearly accessible. Amongst those we reviewed were the recruitment, selection, interview and appointment policy; the induction policy, training and development policy; performance and appraisal policy; clinical audit and discrepancy policy.

The service had further updated their statement of purpose since our last inspection to reflect changes to regulated activities, including the provider's cancellation of regulated activities for surgical procedures. The revised statement of purpose was reflective of the service at the time we inspected and relevant for CQC registration purposes.

The service had a service level agreement document and process for sign off whenever any new contract arrangements were in place. Staff described this process fully and how it would be implemented; however, at the time of inspection this had not yet been put into practice due to the lack of opportunity for this.

Management of risk, issues and performance

Leaders and teams had continued to identify systems and processes in relation to the management of risks, issues and performance. There was a system and process in place to assess and monitor the improvements that had been identified and risk management processes were becoming embedded. They had plans to cope with unexpected events.

The revised governance arrangements, incorporating the new meeting schedules and identified leadership responsibilities, provided the mechanism for ongoing oversight and management of risks issues and performance. The service had a risk register which was being developed and intended to be a dashboard report for the future, described as being a 'live' document for the continuing monitoring and management of risks in the service.

Requires Improvement

Diagnostic and screening services

At the time of inspection, the registered manager told us there were no ongoing risks recorded on the risk register as the actions for these had all been completed. However, when we reviewed the risk register on site, we saw there were in fact limited details included of three risks, all related to some of the completed action plans already included in the quality improvement action plan.

The registered manager told us the key risk to the service at the time of inspection was in context of business sustainability and continuity, dependent on future commissioning decisions. During interview discussions, service leaders were able to describe wider potential risks within the service, however we saw the these were not always fully identified or detailed in the risk register. For example, staffing issues including lack of available staffing was described as a possibility, but not specifically identified as a service risk and recorded on the risk register. Overall, there appeared to be a limited understanding of the use of the risk register and what could be considered as a risk in the service, these being mainly interpreted in terms of the business aspects the service.

However, although there was some duplication between the risk register and the quality improvement action plan, we could see there were some systems in place for assessing and monitoring risks issues and performance, with appropriate actions in progress and completed across the service. For example, we also saw there had been work completed to identify risk assessment procedures and to complete risk assessments across the service, both from a clinical and non-clinical perspective. These included various environmental risk assessments for personal safety, mobility and access, lone working, fire risk assessments, and COVID-19 risk assessments. Also, although there was an audit schedule in place, this included several clinical audit outcomes; which at the time of inspection, due to the lack of clinical activity in the service, clinical audit information was not available to be reported.

The service had a business continuity policy, providing detail of emergency events which could have impact on service delivery, together with detailed actions in response to each potential emergency. Included as part of this were the loss of essential utility services, including IT; loss of supply of equipment or consumables; malicious damage, theft or vandalism; outbreak of infectious diseases; and flooding. This policy also outlined the process for 'Contingencies for Staff Unplanned Absence', describing how 'Mediscan operates a "bank" system for absences in order to ensure that we do not have to cancel clinics.'

The quality improvement plan continued to be the main working document relating to operational activity within the service. The quality improvement plan had incorporated responsive actions for each of the improvement actions identified following the regulatory breaches after the latest inspections of August and November 2021. Of these actions, a total of 18 actions had been signed off as completed, with a further 22 marked in progress; some of these further 22 actions were anticipated to be completed in April 2022. Work to progress KPIs for different areas of the service had not yet been fully progressed due to the lack of clinical activity and was due to start in April 2022. From our review of the quality improvement plan during the inspection, the actions were an appropriate record and an accurate reflection of the systems being embedded.

Staff at all levels of the organisation were aware of the quality improvement plan and could describe the processes for reviewing this at management meetings, team meetings, and board meetings, also describing how information was shared with staff from these meetings.