CURX HEALTH LIMITED

CuRx Operational Base

Inspection report

The Mezzanine, Junction 21 Business Park
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Oldham
Lancashire
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Tel: 07716090301

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Overall summary

This service is rated as Requires improvement overall. (Previous inspection 18 September 2018 – Not Rated)

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at CuRx Operational Base to follow up on the breaches identified during the service inspection carried out on 18 September 2018 and as part of our inspection programme.

At our last inspection we identified regulations that were not being met and the provider was told they must**:**

- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.
- Ensure all premises and equipment used by the service provider is fit for use.

There were also areas identified during the last inspection where the provider was recommended to make the following improvements.

- Review the service infection control policy, to ensure that information includes the requirements necessary to undertake scans for patients with suspected or confirmed contagious and communicable diseases and/or suppressed immune systems. The policy should also refer to the procedure for the decontamination of equipment and environment following use by patients with suspected or confirmed contagious or communicable diseases.
- Review the practice's protocols to ensure recommendations made following audit is actioned and the issues identified re audited to improve the quality.
- Review the records kept demonstrating competency training for each staff member.

At the last inspection we asked the provider to make improvements regarding the above breaches and recommendations. We checked these areas as part of this comprehensive inspection and found that there had been some areas of improvement, but these had not been sustained.

We received feedback from 41 patients via completed CQC comments cards as part of this inspection. All the

Summary of findings

comments made were positive about the patient experience and only one comment was negative about not being able to find the location. Positive feedback included comments about how quick the service was, kind and friendly staff, good confidential support given, staff were helpful a kept patient fully informed.

Our key findings were:

- The service was not providing safe services for all areas related to safe systems and processes, in accordance with the relevant regulations. This included not having suitable equipment to deal with medical emergencies.
- There were arrangements for planning and monitoring the number and mix of staff needed.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.
- There were systems for reviewing and investigating when things went wrong and when patient complaints were made. However, there was no formal system for recording and acting on significant events.
- The provider was aware of and complied with the requirements of the Duty of Candour.
- The provider had systems to keep clinicians up to date with current evidence-based practice. The service obtained consent to care and treatment in line with legislation and guidance.
- Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop, however, annual appraisals for relevant staff had not been completed.
- Feedback from patients was positive about how caring staff were and the positive experience they had encountered. Staff recognised the importance of people's dignity and respect.
- The service took account of patient's preferences in terms of choice of locations for having the scans. Patients had good access to appointments and timescales were monitored and discussed widely.
- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. However, several patient safety risks required improvements.
- Staff told us they felt respected and supported. They described an open and honest culture and said they felt comfortable to raise concerns without fear of reprisals.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change services to improve quality.
- All patients were invited to give feedback about their experiences after each scan was performed. We noted positive feedback from patients.

The areas where the provider **must** make improvements as they are in breach of regulations are as follows. The provider must:

- Ensure patients are protected from abuse and improper treatment
- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

(Please see the specific details on action required at the end of this report).

The areas where the provider **should** make improvements are:

- Review the availability of equipment in the practice to manage medical emergencies taking into account the guidelines issued by the Resuscitation Council (UK).
- Review the storage of cleaning materials and cleaning equipment.
- Review the audit arrangements for all sonographers including locums, to ensure an accurate sample of complex and uncomplex scan results are monitored regularly.
- An overall training matrix should be introduced to monitor staff training.
- Review the ways in which significant events are reviewed, investigated and reported.
- Review the information available to inform them that interpretation services are available for patients who did not have English as a first language.

CuRx Operational Base

Detailed findings

Background to this inspection

The service is run by a private organisation named CuRx Health Ltd. The provider registered with CQC in 2017 to provide the regulated activities of treatment of disease disorder or injury, diagnostic and screening procedures, surgical procedures and family planning. At registration these regulated activities were applied for and set up to support the provider when making bids for local NHS contracts which covered these activities.

At the time of inspection, the only regulated activity being carried out was diagnostic and screening. We found that the provider ran a remote ultrasound scanning service commissioned by the local Clinical Commissioning Group (CCG). The service was commissioned as part of a government initiative with a 'any qualified provider' (AQP) structure to improve patient access to diagnosis and management.

The only registered location for the provider is the organisation headquarters at The Mezzanine, Junction 21 Business Park, Gorse Street, Chadderton, Oldham, Lancashire, OL9 9QH. Remote imaging (ultrasound scans) are undertaken across several host locations within a number of GP practices. Service level agreements are in place to support these arrangements. The ultrasound scans available include abdominal, hepato-biliary, liver, gallbladder, pancreas, spleen, pelvic – uterus, ovary and transvaginal scans.

The service currently operates from the main headquarters and from a number of GP practices and community premises across the area. Open times vary at each host location.

The lead clinical director at the service is also the registered manager. A registered manager is a person who is registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We carried out this inspection as a part of our comprehensive inspection programme of independent health providers.

Our inspection team was led by a CQC lead inspector, who was supported by a CQC specialist advisor. The inspection was carried out on 29 August 2019. Prior to the visit, we received some information from the registered manager. During the visit we:

- Spoke with two directors and the company operational lead.
- Spoke with a member of the sonographer team, the health care assistant team and some of the administration support team.
- Reviewed a sample of patient records.
- Reviewed comment cards in which patients shared their views and experiences of the service.

We asked for CQC comment cards to be completed by patients prior to the inspection. We received 41 comment cards which were all positive about the standard of care

received.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Requires improvement

Are services safe?

Our findings

We rated safe as Requires improvement because:

- Recruitment information to show that fit and proper people were employed at the service required improvement.
- The service did not have suitable equipment to deal with medical emergencies and a risk assessment was not in place.
- There was no formal system for recording and acting on significant events.
- Staff were trained in safeguarding matters however, clinical staff had not completed training at an appropriate level.

Safety systems and processes

The provider had some systems to keep patients safe and safeguarded from abuse, however, these required improvements.

- There was a lead member of staff for safeguarding processes and procedures. There were policies covering adult and child safeguarding which were accessible to all staff. Staff were trained in safeguarding matters, however, one member of clinical staff had not completed training at an appropriate level.
- The premises were not owned by the provider, a lease arrangement was in place. The provider had service specific policies that staff had access to. The building displayed a health and safety poster with contact details of health and safety representatives that staff could contact if they had any concerns. A risk assessment of the premises was undertaken in January 2018. We observed the cleaning materials and cleaning equipment was not stored in a locked cupboard but underneath the stairs. We were told that this had been removed immediately after the inspection. Risk assessments such as the Control of Substances hazardous the Health (COSHH) risk assessments were not in place.
- Fire training had been carried out for staff and appropriate fire safety checks were undertaken. Since the last inspection a fire risk assessment of the building had been completed in January 2019. However, the action plan identified as part of this assessment had not been updated by the provider and there was no evidence to show that fire safety recommendations made had been acted upon. We observed that fire extinguishers were out of date and there were no contracts in place for the regular service of this equipment. Action was taken by the provider at the time of inspection to rectify these safety concerns.
- The service had a business continuity plan in place that was available to all staff.
- We looked at the arrangements for the management and maintenance of the scanning equipment in use. The service has four scanning machines in place; we were told that two of these were in active use and the other two were back up machines. Contracts were in place for the preventative maintenance of this equipment. Records showed that two of the machines had been serviced recently and we were told that arrangements were in place for the other two following the inspection. We were assured that the back-up machines would not be used without a full service being carried out.
- The service maintained appropriate standards of cleanliness and hygiene across all areas. There were infection prevention and control policies and protocols and staff had received training in infection control. However, at our last inspection we identified an improvement that the policy should include information on the requirement to undertake scans for patients with suspected or confirmed contagious and communicable diseases and/or suppressed immune systems. The policy also did not refer to the procedure for the decontamination of equipment and environment following use by patients with suspected or confirmed contagious or communicable diseases. The provider had updated their policy, but reference to these issues was not included. The last inspection control audit had been carried out in September 2018 and showed the practice was fully compliant.
- The provider carried out recruitment checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Concerns were raised at the last inspection about the provider not being able to demonstrate appropriate recruitment checks prior to employment. At this inspection we observed that

Requires improvement

Are services safe?

- Policies were in place to say that Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). However, on the day of inspection we found that one member of staff had a DBS check from a previous employer. The provider had accepted this and completed a new one in August 2019. At the time of inspection, the results were not known.

Risks to patients

There were some systems to assess, monitor and manage risks to patient safety, however, these required improvements.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an induction system for new or agency staff tailored to their role and we observed records for this.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They described how to identify and manage patients with severe infections.
- The service did not have suitable equipment to deal with medical emergencies and a risk assessment was not in place for this decision. Emergency oxygen therapy and an automated defibrillator were not in place.
- There were appropriate indemnity arrangements in place.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Protocols were in place for managing ultrasound scanning referrals from GPs. This included checking and prioritisation of referrals. We saw that actions were taken by the team when requests made were inadequate or held the wrong patient information.
- The records we saw showed that information collected identified patients that may be vulnerable or may need additional support.
- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading. We were told that scans were stored in an i Cloud storage arrangement. However, we were not assured that a formal procedure was in place for this to ensure all patient scans were stored for the appropriate timescales.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

No medicines were stored or administered at the service.

Track record on safety and incidents

The service had a good safety record.

- There were some risk assessments in relation to safety issues however, these required improving.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned, and improvements made

The service learned and made improvements when things went wrong.

- There were systems for reviewing and investigating when things went wrong and when patient complaints were made. The provider used a system named Corrective and Preventive Action (CAPA) for reviewing patient complaints. This is an aviation tool used to analyse when things go wrong as part of a root course analysis (RCA). We saw some examples of when this had been used for patient complaints.
- There was no formal system for recording and acting on significant events. The provider indicated that the CAPA approach would be used and there were some examples that showed analysis had been undertaken for events that would be significant. We were told there had been no reported significant events at the service.
- All patient complaints were discussed with staff at quarterly meetings to identify any learning that may be needed.
- Staff understood their duty to raise concerns and report incidents.

Requires improvement

Are services safe?

- The provider was aware of and complied with the requirements of the Duty of Candour. The service had systems in place for knowing about notifiable safety incidents
- The service acted on and learned from external safety events as well as patient and medicine safety alerts.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated effective as Good because:

- The provider had systems to keep clinicians up to date with current evidence-based practice. Sonographers assessed needs and undertook ultrasound tests in line with current legislation, standards and guidance supported by clinical pathways and protocols.
- The service obtained consent to care and treatment in line with legislation and guidance.
- Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop, however, annual appraisals for those staff who should have them had not been completed.
- Staff worked together, and worked well with other organisations, to deliver effective care and treatment.

Effective needs assessment, care and treatment

We found that this service was providing effective services in accordance with the relevant regulations.

The provider had systems to keep clinicians up to date with current evidence-based practice. Sonographers assessed needs and undertook ultrasound tests in line with current legislation, standards and guidance supported by clinical pathways and protocols.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Written policies were in place.
- Sonographers we spoke with understood the requirements of legislation and guidance when considering consent and decision making.
- The service monitored the process for seeking consent appropriately.
- Staff we spoke with ensured that patients understood what was involved in the procedures for their treatment.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice.

- Sonographers assessed needs and undertook ultrasound tests in line with current legislation, standards and guidance supported by clinical pathways and protocols.
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

- The service monitored that guidelines were followed through audits and random sample checks of patient ultrasound scans. This was in line with the monitoring requirements reported to the CCG as part of the contract.
- Clinical audit had a positive impact on quality of care and outcomes for patients. A number of audits had been carried out by a consultant radiographer who worked for the provider. We observed that audits were undertaken of the individual sonographers work and results were then discussed individually. We were not assured that the same audits were undertaken for locum sonographers. There was clear evidence of action to resolve concerns and improve quality. We saw that samples of what was referred to as 'complex' scans were completed but less evidence that the 'unremarkable' scans were also included in sufficient numbers in the audits carried out.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff.
- Relevant professionals (radiographers) were registered with the Health and Care Professions Council (HCPC) and were up to date with revalidation
- Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop, however, annual appraisals for those staff who should have them had not been completed.
- An overall training matrix was not in place.

Good

Are services effective?

(for example, treatment is effective)

Coordinating patient care and information sharing

Staff worked together, and worked well with other organisations, to deliver effective care and treatment.

- The provider had a secure IT system to coordinate patient care and to share information. Systems were in place for communications with the patients GP referrer. This mostly included electronic communications with some fax communications taking place. We found that a referral would be made to the service and prompt appointments would be given to patients. Letters were followed up with a telephone call and text messages to patients to reduce the numbers of missed appointments.
- Systems were in place to monitor how long it took for patients to receive an appointment and for how long it took to provide GPs with the reported ultrasound scans. Imaging and initial and final reporting timescales were closely monitored by the provider.
- All patients were asked for consent to share details and information related to their scans.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Written policies were in place.
- Sonographers we spoke with understood the requirements of legislation and guidance when considering consent and decision making.
- The service monitored the process for seeking consent appropriately.
- Staff we spoke with ensured that patients understood what was involved in the procedures for their treatment.

Good

Are services caring?

Our findings

We rated caring as Good because:

- Feedback from patients was positive about how caring staff were and the positive experience they had encountered.
- The service respected patients' privacy and dignity.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the patient's experience.
- Feedback from patients was positive about the way staff treat people
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.

Overall, involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

- Patients were offered written information about the ultrasound scan they had been referred to the service for. The provider had a public website patients and GPs could use to understand the procedures involved. This information included contact details for the service, the locations used by the provider and the opening hours. For each imaging procedure, patients were sent a letter which included the preparation required for the procedure and how results would be communicated back to their GP.
- We spoke with staff about access to interpretation services for patients who did not have English as a first language. We found there was no arrangments to access interpreter services if needed and no information in languages other than English, informing patients this service was available.
- Patients told us through comment cards, that they felt listened to and supported by staff and had enough time during consultations to make an informed decision about the investigations available to them.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- There was one treatment room in the head office location and we observed that the doors were closed during consultations.
- Chaperone arrangements were in place for patients when intimate personal scans were undertaken.
- On entry to the service the patients were greeted by a reception staff member and directed to a waiting area on the lower ground floor.
- Positive feedback was seen for how staff treated patients in the provider's patient survey which was completed at the end of each clinic.
- Care Quality Commission comment cards we received were positive about the service experienced.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated responsive as Good because:

- The service took account of patient's preferences in terms of choice of locations for having the scans.
- Patients had good access to appointments and timescales were monitored and discussed widely.
- The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

Responding to and meeting people's needs

The service organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of their patients and improved services in response to those needs.
- Staff took account of patient needs and preferences when appointments were made and depending on the urgency of the referral.
- Verbal and written information was provided to patients. For example, appointment letters were sent to patients followed up by a telephone call and text message.
- We were told that at the time of booking, if patients told the administrator that they had complex needs and required more time this would be arranged.
- The service made reasonable adjustments when patients found it hard to access the service.
- Verbal and written information was provided to patients. For example, letters were sent to patients followed up by a telephone call and text message.
- The facilities and premises were appropriate for the services delivered.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately. Key performance indicators for these were monitored by the local clinical commissioning group (CCG).
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- Referrals and transfers to other services were undertaken in a timely way.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The service informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had complaint policy and procedures in place. The service learned lessons from individual concerns, complaints and from analysis of trends. It acted as a result to improve the quality of care.

Are services well-led?

Requires improvement

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Our findings

We rated well-led as Requires improvement because:

- Although actions were taken for areas of non-compliance with the regulations at the last inspection, these improvements had not been sustained.
- The management of governance and patient safety risks required improvements.

Leadership capacity and capability;

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Staff told us that leaders were visible and approachable. They told us the management team worked closely with staff to make sure they prioritised compassionate and inclusive leadership.
- The service recently had changes to the operational lead role and this had resulted in new systems being developed and embedded. We were told by the new manager that they were well supported by the provider with regular contact and communications.
- The service had undergone a lot of staff changes over the previous 12 months and there had been a high turnover of staff at the service. New staff we spoke with told us how supportive the management team had been as they developed in their new roles.

Vision and strategy

The service had a clear vision and strategy to deliver high quality care and promote good outcomes for patients.

- The management team presented a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- The aims of the service and the goals set were in line with health needs of the local population and had been commissioned and developed with support from the local Clinical Commissioning Groups (CCG).
- Staff we spoke with were aware of and understood the vision, values and strategy and their role in achieving them
- The service monitored progress against delivery of the strategy.

Culture

Overall the service had a culture of high-quality sustainable care.

- Staff told us they felt respected and supported. They described an open and honest culture and said they felt comfortable to raise concerns without fear of reprisals.
- Complaints were managed in a transparent way and were shared with the local Clinical Commissioning Group (CCG) for monitoring. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- There were processes for providing all staff with the development they need. Staff told us they were well supported with training opportunities, however, annual appraisals were not taking place. Clinical staff were considered valued members of the team.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff felt they were treated equally.
- We observed positive relationships between staff and teams.

Governance arrangements

There were identified responsibilities, roles and systems of accountability to support good governance and management, however, these required improvements

- Structures, processes and systems to support good governance and management were set out, understood and effective. However, the management of risk required improvements.
- Staff we spoke with were clear on their roles and accountabilities.
- Leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. Annual governance meetings took place to update policies and procedures.

Are services well-led?

Requires improvement

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Managing risks, issues and performance

There were processes in place for managing risks, issues and performance, however, these required improvements.

- There were systems and processes to identify, understand, monitor and manage risks however, patient safety risk monitoring required improvements. We found there were health and safety risks not known by the provider, for example, we identified that fire extinguishers were out of date.
- Although actions were taken at the time of the last inspection, for example relating to the safe recruitment of staff, we found concerns relating to the checks completed by the provider at this inspection.
- We noted that the transport of scanning equipment involved a number of moving and handling risks. For example, the equipment was heavy to lift and some of the bags used for this had broken handles. The provider had not completed a moving and handling risk assessment for the remote use of this equipment. We were told that staff members used their own cars to move scanning equipment across the locations and there was no additional insurance cover for staff to undertake this for work purposes.
- The service had processes to manage current and future performance. However, concerns about patient safety risks had been identified at the last inspection and whilst actions were taken at the time, these improvements had not been sustained.
- Performance of clinical staff was demonstrated through audit of their scanning and referral decisions. Leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change services to improve quality.
- The provider had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Data security policies and procedures were in place, but day-to-day practice did not necessarily reflect them. We found that patient information, such as scans were held on portable hard drives and they were not kept secure. There was no back up system for the hard drive, information was sent after the inspection to show the provider had acted to rectify this. The sonographers used portable flash drive when out in the field however, these drives were not encrypted.
- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in staff meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service submitted data or notifications to external organisations as required. Targets and KPIs were monitored closely by the local CCG.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. However, individual patient records were printed and used by staff and stored in a filing cabinet that was not lockable. Information was sent to us following inspection to show that appropriate actions were taken at the time of inspection to rectify this.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- The service encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture. All patients were invited to give feedback about their experiences after each scan was performed. We noted positive feedback form patients.
- Staff could describe to us the systems in place to give feedback. They told us informal arrangements were in place or their views would be considered during quarterly staff meetings.

Are services well-led?

Requires improvement

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- The service made use of internal complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

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 Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **There were no Control of Substances hazardous to Health (COSHH) risk assessments completed.** **The infection control risk assessment and policy did not include information on the requirement to undertake scans for patients with suspected or confirmed contagious and communicable diseases and/or suppressed immune systems.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Clinical staff had not completed safeguarding training at an appropriate level.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The provider did not operate effective recruitment procedures. Appropriate fitness checks such as a Disclosure and Barring Check was not completed prior to the employment of each staff member.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Patient scans were stored with an i Cloud storage arrangement however, we were not assured that a**

This section is primarily information for the provider

Requirement notices

formal procedure was in place for this to ensure all patient scans were stored for the appropriate timescales. The sonographers used portable flash drive when out in the field however, these drives were not encrypted.

Annual appraisals for appropriate staff had not been completed.

The transport of scanning equipment involved a number of moving and handling risks. The provider had not completed a moving and handling risk assessment for the remote use of this equipment.

Staff members used their own cars to move scanning equipment across the locations and there was no additional insurance cover for staff to undertake this for work purposes.

Actions required following a fire safety risk assessment completed in January 2018 had not been addressed.