

Essex Ultrasound & Medical Services 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

Good



Are services safe?

Good



Are services well-led?

Good



Summary of findings

Overall summary

Our rating of the service stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service had systems to manage safety incidents.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's values and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- While most feedback from referring professionals was good, there was some areas of inconsistency in adherence to scan protocols.
- Staff managed safety incidents but there was a lack of centralised recording that meant it was difficult to track themes categories of incidents.

Summary of findings

Our judgements about each of the main services

Service

**Diagnostic
imaging**

Rating

Good



Summary of each main service

We rated this service as good because it was safe and well led. Please see our main summary for more information.

Summary of findings

Contents

Summary of this inspection

Background to Essex Ultrasound & Medical Services Limited	5
Information about Essex Ultrasound & Medical Services Limited	5

Our findings from this inspection

Overview of ratings	7
Our findings by main service	8

Summary of this inspection

Background to Essex Ultrasound & Medical Services Limited

Essex Ultrasound and Medical Services is operated by Essex Ultrasound and Medical Services Limited. The service opened in October 2016 and is based in Canvey Island, Essex. The service serves communities across a wide geographic area from rented space in clinical premises, such as primary care hubs and GP surgeries. The provider does not operate its own clinical centre.

The provider is registered to provider care under the following regulated activities:

- Diagnostic and screening procedures

The service provides ultrasound scans to people over the age of 18 across a range of modes including musculoskeletal, kidney, bladder, thyroid, transvaginal, and abdominal.

The service has had a registered manager in post since October 2016 who is also the business owner.

Patients are referred from NHS services as part of the national 'any qualified provider' (AQP) scheme to increase capacity, reduce waiting times, and reduce unnecessary referrals to secondary care.

We last inspected the service in October 2018 and rated it good overall and good in each domain except effective, which we did not rate. At that inspection we found the provider was in breach of Regulation 12 (2)(3) of the CQC (Registration) Regulations 2009. This was because the service was providing care to people outside of the scope of its statement of purpose. We also told the service it should improve standards of privacy for patients in scanning rooms. At this inspection we found the registered manager had addressed both issues.

How we carried out this inspection

We carried out inspections of the service on 1 September 2022 and 16 September 2022 using our focused methodology. We included the provider's registered address and a satellite site in Westcliff-on-Sea in our inspection. We gave the service short notice of the inspection dates as we needed to be sure clinical services would be in session when we visited.

The inspection team consisted of a lead inspector and a diagnostic imaging specialist advisor with support from an inspection manager. During our inspection we spoke with staff and patients, observed care being delivered, reviewed clinical records, and carried out an inspection of the various clinical environments. After our inspection the provider sent us additional evidence, which we considered to come to our ratings.

Areas such as facilities management, fire safety, and infection control in public areas were managed by other organisations, such as the building operators. We refer to these services in our report for context, but they do not form part of our ratings.

We undertook this inspection as part of a random selection of services which have had a recent Direct Monitoring Approach (DMA) assessment where no further action was needed to seek assurance about this decision and to identify learning about the DMA process.

Summary of this inspection

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

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a trust **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 they continue to improve the consistency of scanning and reporting to protocols.
- The service should consider implementing a centralised incident tracking system that enables the identification of themes for future prevention.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Not inspected	Not inspected	Not inspected	Good	Good
Overall	Good	Not inspected	Not inspected	Not inspected	Good	Good

Diagnostic imaging

Safe	Good 
Well-led	Good 

Are Diagnostic imaging safe?

Good 

Our rating of safe stayed the same. We rated it as good.

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. The service had a target of 95% completion, which they consistently met. Mandatory training was comprehensive and met the needs of patients and staff based on their role. It included modules such as health and safety, First Aid, and infection control, which staff applied at all clinics from which they worked. As a service providing care only for NHS patients, staff had access to NHS training and the registered manager supplemented this with ad-hoc specialist training when the need arose.

The senior team monitored mandatory training and alerted staff when they needed to update their training. Staff accessed training remotely, which helped temporary staff keep up to date.

All sonographers held advanced practitioner status with NHS trusts and the service updated training requirements in line with national Society and College of Radiographers and British Medical Ultrasound Society guidelines.

Safeguarding

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

Staff maintained training specific for their role on how to recognise and report abuse. All clinical staff were required to maintain level 3 adults and children safeguarding training in line with the Royal College of Nursing intercollegiate document. At the time of our inspection, all staff were up to date. The registered manager was the safeguarding lead and held level 4 training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff demonstrated attention to detail and discretion when escalating concerns about a patient's potential safeguarding risk. Staff told us about an instance where they worked skilfully to secure help for a patient without increasing their risk. This reflected good practice.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The provider had an established safeguarding policy and escalation procedures. These reflected the geographically fragmented nature of the service and meant staff followed escalation and referral processes consistently. For example, staff maintained up to date contact information for local safeguarding teams, including out of hours crisis teams, at each clinical site.

Diagnostic imaging

Staff followed safe procedures for children accompanying patients to a scan, such as by allowing them to stay with the adult in the scan room.

All scans took place with a chaperone present. This was a service standard and ensured a safe care environment. Patients could request male or female staff in advance, such as for intimate scans.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Staff worked in clinical environments rented from other organisations. The provider had service level agreements with each host site to ensure clinical areas and furnishings were clean and well-maintained. Staff working from clinical sites were responsible for checking local standards and ensuring the environment was ready for use. We saw this in practice and staff carried out their own cleaning before and after each patient list.

Clinical areas we inspected were visibly clean and had suitable furnishings which were clean and well-maintained.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff carried PPE with them in line with the provider's standards. This meant staff always had the appropriate stock at each clinical site. Staff wore and managed PPE appropriately during our clinical site inspection.

Staff said they cleaned equipment after each patient contact, and we saw this in practice during our site visit. Disposable privacy curtains were dated and within their expiry date.

Staff cleaned transvaginal probes using a specific 3 point decontamination system. We observed good standards of practice. For example, staff used antibacterial hand gel appropriately and practiced national hand hygiene standards between patients.

The senior team audited hand hygiene and PPE practices at each clinical site as part of wider IPC checks. The most recent audits for a sample of 3 clinical sites indicated consistently good standards.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Clinical spaces in some sites were shared with other services. In these cases, the service had an agreement with the building operator to maintain standards of cleanliness.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The provider delivered services from rented clinical premises in facilities such as primary care centres and GP surgeries. Premises were purpose built for clinical care and the registered manager inspected new premises before establishing services from them to ensure they were in a good state of repair and suitable for safe ultrasound scans. The design of the two clinical sites we inspected followed national guidance.

Diagnostic imaging

The service had enough suitable equipment to help staff safely care for patients. Staff carried out daily safety checks of specialist equipment such as ultrasound scanners. The registered manager used a planned preventative maintenance system to maximise use of the equipment whilst ensuring it was safe and used within manufacturer guidance. The service had a service level agreement for urgent equipment repairs and engineer call-out to reduce the risk of disruption in the event of a failure.

Staff managed clinical waste safely, including the storage and disposal of hazardous waste, through service level agreements with third parties.

Staff received a local fire safety induction from site management teams. This supplemented the standard fire safety training undertaken by the provider. Staff demonstrated good knowledge of escape routes and local policies during our clinical site inspection.

Assessing and responding to patient risk

The provider had processes to assess and respond to deteriorating patients.

Staff delivered care from rented premises in other healthcare organisations. They underwent an orientation at each site to familiarise themselves with emergency procedures and equipment.

All staff maintained up to date training in basic life support, which included cardiopulmonary resuscitation. Each clinical site from which the service operated had emergency medical equipment, including an automatic external defibrillator (AED). Staff were trained to operate such equipment and local service level agreements ensured they had access. Local inductions included the location of such equipment.

The provider had protocols for patient deterioration, including for the escalation of an acute medical need.

An NHS radiologist vetted each urgent referral to ensure the service was equipped to provide safe care. For example, the service could not scan patients who required a hoist. In such cases the registered manager contacted the referrer to find an alternative service. Referrers were required to complete a safety risk assessment and screening questionnaire for each patient, which included key medical information needed for safe care.

Staff confirmed allergies with patients before carrying out scans that presented a risk. For example, they checked if patients had a latex allergy before transvaginal scans as the probe was covered with a condom. Latex-free condoms were available in such cases.

Staff used the national standard three-point identification check for each patient. We saw this in practice during our inspection and staff consistently cross-referenced patient's answers with referral documentation. This was best practice and ensured staff scanned the correct patient.

In the event the sonographer found sinister pathology, or another reason for urgent escalation, the sonographer contacted the referrer immediately. They did this before the patient left the clinic to ensure the next steps were clear. The registered manager called the patient two days after such an event to ensure they had received contact from the referrer. If this had not happened, the manager escalated the issue with the referrer's organisation. This process ensured a rapid response to urgent results. Two NHS consultants provided on-demand support and sonographers contacted them for guidance in the event they could not reach the refer.

Diagnostic imaging

Where sonographers found pathology that suggested patients needed to be seen within the NHS 2 week wait system for oncology, they referred patients into specialist services.

Staff arranged rescans of patients who presented with specific risks. For example, if staff noticed a cyst that needed further exploration, they arranged for patients to return. If a patient arrived and had not adhered to pre-scan requirements, such as fasting for patients with a certain body mass index, or a full bladder for other scans, staff could not proceed and would rebook them.

Staffing

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

The service arranged clinics with enough staff to keep patients safe. A sonographer and a healthcare assistant (HCA) provided care to each patient with support from a dedicated administration team. Staff worked for the service under a variety of contracts, including full time contracts and on an as-needed self-employed basis. Fifteen sonographers and 10 HCAs regularly worked for the service. Staff worked flexibly and planned shifts in advance based on demand over a six day working week, from Monday to Saturday.

Each sonographer completed a formal induction with the provider, which included a practical, clinical day with the lead sonographer. This ensured staff had consistent knowledge of scanning protocols and procedures across all clinical sites

Care was provided as one element of NHS care pathways and staff did not have responsibility for long-term or multidisciplinary care. The service provided a scan and reporting function only and patients' substantive clinicians were responsible for their overall care and treatment.

The service was compliant with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the safe recruitment of staff. The registered manager carried out a Disclosure Barring Service (DBS) check for each member of staff before they started undertaking work. They carried out a new DBS check every three years.

The registered manager, or their deputy, was on-call whenever clinical services were provided. They held local escalation plans to support staff experiencing difficulties in any clinic.

The service reported low levels of staff sickness at 0.5% in the previous 12 months. The registered manager tracked staff turnover, which was 7.6% in the previous 12 months. This figure which included five staff who either completed an apprenticeship or moved into a post in the local NHS trust.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Sonographers prepared reports in real time during scans and transmitted these to referrers within 24 hours for urgent referrals and within five days for routine referrals.

Diagnostic imaging

Staff sent scan images and reports to the provider's clinical quality team immediately using an image exchange portal (IEP). This team reviewed the reports for quality then sent them using secure systems to the referrer in line with each agreement. Each referring organisation had access to the IEP, which enabled secure sharing and archiving.

We looked at 4 sets of patient records and found staff were consistent in their level of detail and scan reporting. They documented details of the examination and scan carried out alongside clinical justification, scan findings, and recommended next steps.

The registered manager carried out spot checks on sonographer images and reports and encouraged feedback from referring doctors. This supplemented the formal quality assurance system and meant the service had continual assurance of clinical record standards.

The lead sonographer carried out spot checks on sonographer images and reports and encouraged feedback from referring doctors. This supplemented the formal quality assurance system and meant the service had continual assurance of clinical record standards.

Medicines

The service did not administer, manage, dispense, or prescribe medicines.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. The service ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. They knew how to raise concerns and reported incidents and near misses in line with the service's policy. Staff reported incidents using an electronic system, which they could access from any clinical site and from home. The registered manager shared incident reports with commissioners as part of clinical governance processes. This reflected the geographically spread nature of the service. Staff described these processes to us although there had been no incidents reported at the sites we visited and were not aware of incidents at other sites.

Staff we spoke with understood the duty of candour. There had been no incidents that required the use of the duty although staff could give examples of when it would be needed.

The service documented 1 incident in the previous 12 months, which related to an inaccurate referral from an NHS trust. The registered manager worked with the referring team to reduce the risk of future occurrences. However, information sent to staff by the lead sonographer included a wide range of learning and feedback, which suggested not all incidents were recorded or tracked centrally.

The senior staff of host primary care centres shared incidents with the provider team and staff who delivered care. This ensured staff who worked across multiple sites had access to learning.

The lead sonographer provided quarterly safety updates to colleagues that reflecting learning from issues, incidents, near misses, and feedback. For example, recent learning reminded staff to consider sinister pathology regardless of the patient's age. They also worked with the team to ensure they considered each patient's self-described medical history in the context of their symptoms to ensure scans were appropriate.

Diagnostic imaging

The registered manager received national patient safety alerts and adjusted practice and policy accordingly. They shared relevant updates with sonographers and HCAs.

Are Diagnostic imaging well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

The registered manager had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The company director was the clinical lead and registered manager. They were responsible for all senior functions of the service and were supported by a deputy manager, a lead sonographer, an administration manager and their team. The lead sonographer was registered with the Health and Care Professions Council (HCPC) as an ultrasound superintendent and worked substantively in an NHS service. This reflected a senior leadership system that was appropriate for the service and patient needs.

The clinical lead was a GP lead in 1 of the centres from which the service provided care. They provided oversight to sonographers and reviewed policies.

A manager was always available on call whenever a clinic list was running. The registered manager was actively involved in the running of the service and supported the administration team when needed.

The registered manager maintained regular contact with staff through electronic means and meetings. Staff said they felt senior staff were approachable and accessible and responded quickly to requests.

The registered manager empowered staff to plan their development and to gain new skills. They facilitated opportunities for promotion and professional progression such as by supporting staff to undertake university-level study.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with relevant stakeholders. The vision and strategy were focused on sustainability and expansion of services and aligned to local plans within the wider health economy.

The provider's strategy focused on addressing capacity shortages and reducing waiting lists across the commissioning areas. The registered manager proactively built relationships with other services to increase awareness of the service and offer opportunities for increased care capacity.

The provider had set up services to support NHS trusts and services and reduce waiting times for patients. Staff demonstrated a commitment to this ethos and understand how to provide care for patients who had waited significant periods of time and were often worried or anxious.

Diagnostic imaging

The senior team worked with partners across regional health structures to plan and structure services in accordance with local needs as part of a strategy to expand capacity.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

The provider facilitated an open culture in which staff were encouraged to speak up and contribute to the running of the service. The senior team worked to help staff feel part of a team despite the geographic spread of clinical care, which staff said worked well in practice.

Staff told us the working culture was open and friendly and they enjoyed working for the organisation. This extended to colleagues outside of the organisation. For example, staff working in the primary care centres we visited during our inspection spoke of good relationships with the provider and its staff. The team had developed good communication with GPs who shared primary care facilities and provided on-demand, urgent scans on request where a GP found an urgent need. This was good practice and helped reduce the burden of waiting times.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet.

The registered manager, lead sonographer, an NHS trust consultant, and a GP lead formed the clinical governance team. They operated on a 'case study' basis, which meant they reviewed specific cases of care and provided feedback on results, health and safety, safeguarding, and any other related areas. Care and policies were benchmarked with Royal College of Radiologists and British Medical Ultrasound Society guidance.

The provider delivered scanning services from a range of clinical settings. We carried out our inspection at two multi-provider primary care centres that included a range of community NHS services. The registered manager was responsible for the governance and contractual arrangements of relationships and agreements between this provider and the building operators. They kept records of fire safety checks and audits, security systems, and service level agreements for reception staffing and facilities such as toilets and waiting areas. This provided assurance of safe working relationships.

The business model and related governance were well established, and the service had a good relationship with commissioners, NHS trusts, and regional GPs. During the COVID-19 pandemic, the service maintained continuous care except for two weeks due to personal protective equipment (PPE) shortages.

The provider had well-established processes and systems in place to support staff working on a mobile basis in different clinics. This included on-demand support for IT issues, equipment failures, and support with accessing clinical referral records.

The senior team established service level agreements with each clinic operator to ensure staff had appropriate local guidance and induction. They monitored arrangements on an ongoing basis through contract monitoring and engagement.

Staff said they had regular opportunities to meet the senior team and discuss performance.

Diagnostic imaging

A dedicated administration team used a quality assurance process to review sonographer reports before sending them to the referrer. The team worked with the lead sonographer if they found discrepancies in measurements to review the scan and referral.

Management of risk, issues and performance

The registered manager used systems to manage performance effectively. They identified and managed risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The registered manager maintained a clinical governance and risk management policy. This had a clear structure with well-defined risk assessments, mitigation, and named responsibility. The registered manager worked with local site managers from other organisations to establish consistent understanding and mitigation of risks.

The service identified reduced availability of GPs during and after COVID-19 restrictions as a key risk to patients and diagnostics. For example, the service scanned patients as soon as one week within a referral but some referring services had no follow-up appointments available for over one month. The registered manager alleviated this risk by liaising directly with referring professionals to establish expected response times after results were sent to them.

The registered manager tracked referral to scan times as a key performance measure. The service performed consistently well. In the previous six months, staff saw 96% of patients with an urgent referral within 1 week and 100% within 2 weeks. Amongst routine referrals, they saw 100% of patients within 5 weeks.

The registered manager tracked patients who did not attend or who the service could not contact following a referral as part of clinical governance and risk management. Where this occurred, the service contacted the referring clinician for follow-up.

The registered manager met periodically with commissioners as part of contract monitoring to review incidents, complaints, and key performance indicators.

Processes were in place to enable staff to get help in the event of an emergency. In the clinics we visited, ultrasound rooms had emergency alarms connected to the main reception.

The registered manager worked with the operator of each building to manage risks associated with multiple-occupancy clinical premises.

Between April 2022 and August 2022, the service met all reporting agreements with referring services. For example, 100% of urgent reports were transmitted to the referring clinician within 3 days and 100% of routine reports were transmitted within 5 days.

The registered manager and lead sonographer audited 5% of all ultrasound scans and reports. Alongside a peer review process, this formed the service's quality assurance system. Audits showed consistently good standards of work with 100% compliance with expected standards in the previous 6 months. However, feedback from some referrers indicated a need for improved consistency when reporting, such as clearer written analysis of the findings, to ensure they were in line with expected protocols. The team met to discuss such feedback and used case studies and peer reviews to identify opportunities for improvement.

Information Management

Information systems were integrated and secure.

Diagnostic imaging

The service reported waiting and reporting times to commissioners as a key performance indicator.

Staff were required to complete information governance and general data protection regulations (GDPR) training that included the risks of handling information and data remotely. Staff worked within the provider's data protection policies and avoided risks associated with data breaches. The registered manager acted on near misses in relation to data breaches and the lead sonographer carried out spot checks of practice.

Most information systems related to the image exchange portal (IEP), which was part of a regional electronic records system used by primary care services. Staff used both systems within data sharing agreements established with referring NHS services. Systems were encrypted and managed jointly by the IT teams of both organisations involved in a referral using clear data sharing agreements. The provider retained access to scans and records in the event of a future investigation or complaint.

The registered manager provided monitoring data to commissioners as part of contractual obligations. Commissioners used these data to ensure service compliance and efficacy.

Engagement

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

The provider recognised the needs of staff who worked remotely and sporadically and was working to implement consistent engagement. Sonographers spoke positively about this and said they felt valued and listened to.

The provider expanded engagement by implementing an intranet platform for staff to use to support communication. This was a virtual space staff used to exchange ideas and share cases with learning from scans. Staff spoke positively about this and said it was helpful during lists to get support for onward referrals.

Staff spoke with patients ahead of an appointment to ensure they had all the information they needed and were prepared. For example, some patients were required to fast for 6 hours before a scan and others needed to plan to attend with a full or empty bladder. Sonographers discussed scans, referrals, and next steps with patients at the time of their scan.

The senior team worked with referring GPs and local trusts to improved standards of referrals and reduce the need for rescans. For example, the registered manager met with referring consultants after the service identified a discrepancy between the referral instructions and the patient's needs. The incident related to poor information management in the referring organisation and the registered manager worked with them to improve standards.

The service had built its reputation and good standing by gaining the trust of referring consultants, radiologists, and GPs through consistent, good quality care. Staff based decisions on opening new clinical sites around convenience for patients as part of engagement with them to understand important factors in their care. For example, the service required every centre have free parking, to offer clean, modern facilities, and to have air conditioning and heating systems.

The service worked with commissioners, NHS services, and community providers to coordinate the service and develop clinical capacity.

Diagnostic imaging

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The registered manager had a good awareness of areas of low capacity in the region and targeted commissioners with structured plans to reduce wait times. Staff worked flexibly to address changes in demand and the registered manager sought feedback from referrers to understand how they could improve.

The service was accredited to train and develop apprentices under a national scheme, which the registered manager facilitated as part of a strategy for future capacity planning. Staff provided placements for student sonographers and healthcare assistants. This reflected the registered manager's focus on capacity and succession planning and had resulted in 3 students successfully gaining places on sonographer university courses.

The service had established educational relationships with consultants in 2 out-of-area NHS trusts. The consultants provided staff with on-demand advice and guidance about national standards and thresholds of care and provided specialist training and updates.

The registered manager maintained an up to date understanding of national work and changes relating to sonographers. They were monitoring progress by the Society of Radiographers to set up a national professional register of sonographers.