The Mary How Trust for Cancer Prevention

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Inspection report

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

Ratings

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

Summary of findings

Overall summary

The service had not been previously rated. We rated it as requires improvement because:

- The service had enough staff to care for patients and keep them safe. The service controlled infection risk well. Staff kept good care records.
- Staff provided good screening services to patients. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, and had access to good information. Key services were available five days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their screening. They provided emotional support to patients.
- The service planned screening services to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for a screening appointment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. The service had a vision and it was focused on the needs of patients. Staff felt respected, supported and valued. Staff were clear about their roles and accountabilities. The service engaged well to plan and manage services and all staff were committed to improving services continually.

However:

- Staff did not always complete mandatory training in key skills and did not always have the relevant level of safeguarding adults and children training. Not all staff understood how to report safeguarding concerns.
- The manager did not always manage safety incidents well and did not always identify learned lessons from them.
- The service did not have assurance staff were competent in their role. The service did not have assurance staff were trained and competent to use equipment.
- Staff collected limited safety information and they did not use it to improve the service. Managers did not formally monitor the effectiveness of the service.
- The service did not have robust assurance processes, for example the service had not ensured persons employed met Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Therefore, the service could not be sure staff were proper persons.
- The service did not always identify relevant risks due to limited assurance processes.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Requires Improvement 	The service had not been previously rated. We rated it as requires improvement because: • The service had enough staff to care for patients and keep them safe. The service controlled infection risk well. Staff kept good care records. • Staff provided good screening services to patients. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, and had access to good information. Key services were available five days a week. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their screening. They provided emotional support to patients. • The service planned screening services to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for a screening appointment. • Leaders ran services well using reliable information systems and supported staff to develop their skills. The service had a vision and it was focused on the needs of patients. Staff felt respected, supported and valued. Staff were clear about their roles and accountabilities. The service engaged well to plan and manage services and all staff were committed to improving services continually. However: • Staff did not always complete mandatory training in key skills and did not always have the relevant level of safeguarding adults and children training. Not all staff understood how to report safeguarding concerns.

Summary of findings

- The manager did not always manage safety incidents well and did not always identify learned lessons from them.
- The service did not have assurance staff were competent in their role. The service did not have assurance staff were trained and competent to use equipment.
- Staff collected limited safety information and they did not use it to improve the service. Managers did not formally monitor the effectiveness of the service.
- The service did not have robust assurance processes, for example the service had not ensured persons employed met Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Therefore, the service could not be sure staff were proper persons.
- The service did not always identify relevant risks due to limited assurance processes.

Summary of findings

Contents

Summary of this inspection

Background to The Mary How Trust for Cancer Prevention

The Mary How Trust for Cancer Prevention is an independent healthcare service registered to provide diagnostic and screening services. The service offers a nurse-led screening appointment which includes blood tests, electrocardiogram (ECG), pulse and blood pressure check, urine sample test and bowel screening test. Advice is provided to patients to improve their general health. The service also offers an ultrasound scan appointment which includes abdominal ultrasound and pelvic ultrasound for women. The service offers health screening for patients who are not under investigation with their GP and do not have symptoms. Payment for the service was voluntary and based on financial affordability to pay.

Most of the staff worked at the service on a part-time basis. Most of the staff had substantive roles in other areas of healthcare.

The service is registered to provide the following regulated activity:

- Diagnostic and screening procedures

The service has a registered manager with the CQC.

The last comprehensive inspection was in February 2013. This inspection was carried out using previous CQC methodology. The service met all standards they were inspected against, but the service was not rated.

How we carried out this inspection

During the inspection the inspection team:

- visited the service and looked at the environment
- spoke with the registered manager for the service
- spoke with four other members of staff including a sonographer, a nurse and administration staff
- observed one patient nurse screening appointment
- spoke to one patient who attended a nurse screening appointment
- reviewed two patient records
- looked at a range of policies, procedures and other documents relating to the running 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.

Areas for improvement

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

Action the service MUST take to improve:

Summary of this inspection

We told the service that it must take action to bring services into line with legal requirements. This action related to diagnostic and screening services.

- The service must ensure that they maintain compliance with safeguarding mandatory training at the appropriate level. (Regulation 13(2))
- The service must ensure they have systems and processes to assess, monitor and improve the quality and safety of the service. (Regulation 17(2)(a))
- The service must ensure that they maintain compliance with mandatory training for all staff. (Regulation 19(1)(b))
- The service must ensure recruitment procedures are robust to provide assurance that persons employed meet Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Regulation 19(2))

Action the service SHOULD take to improve:

- The service should ensure it has arrangements to review or respond to external patient safety alerts, recalls, inquiries, investigations or reviews. (Regulation 12)
- The service should ensure clinical staff have a formal record of competency assessments, to assure themselves that staff are competent to complete screenings. (Regulation 12)
- The service should ensure staff have a clear understanding of the safeguarding policy, who the safeguarding lead for the service is and how to report safeguarding concerns. (Regulation 13)
- The service should ensure they complete regular quality assurance checks for the ultrasound machine, to assure themselves that ultrasound images are of good quality. (Regulation 15)
- The service should ensure they clearly display information about how to raise a concern in patient areas. (Regulation 16)
- The service should ensure they have an assurance process to record completion of cleaning by third party cleaners to assure themselves it has been completed. (Regulation 17)
- The service should ensure they have an assurance process to record that all staff have had training on equipment. (Regulation 17)
- The service should ensure it receives information from and shares information with, staff's other employers to assure themselves that they are regularly reviewing fitness of staff. (Regulation 19)
- The service should ensure all staff have an understanding of duty of candour and how it applies to their role. (Regulation 20)
- The service should consider implementing a chaperone policy.
- The service should consider how to implement independent resolution to complaints.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Diagnostic and screening services

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

Are Diagnostic and screening services safe?

Requires Improvement

Safe had not been previously rated. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff however, not all staff completed it.

Staff received mandatory training however, staff did not always keep up-to-date with it. The mandatory training was comprehensive and met the needs of patients and staff. The service could not be sure all staff had up-to-date knowledge and understanding. The service had a mandatory training policy, which was in date and version controlled. This policy did not outline the expected mandatory training. The service offered mandatory training aligned to the Core Skills Training Framework (CSTF) outlined by Skills for Health. However, not all staff had completed all mandatory training. Administration staff had not completed any of the required mandatory training, other than preventing radicalisation. Laboratory staff had not completed any of the required mandatory training, other than one member of staff who had completed infection prevention and control.

The manager told us they monitored mandatory training and alerted staff when they needed to update their training. The manager reviewed mandatory training completion quarterly and sent out email reminders to staff when mandatory training was due. However, this was not effective as staff were not up-to-date with their mandatory training.

Safeguarding

Not all staff understood how to protect patients from abuse. Not all staff had training at the relevant level on how to recognise and report abuse.

Staff had not completed training at the level specific for their role so the service could not be sure staff had up-to-date understanding about their roles and responsibilities for safeguarding adults. Two out of four nursing staff had completed level 2 safeguarding adults training, the other two nurses had completed level 2 safeguarding adults training. Two out of three sonographers had completed level 2 safeguarding adults training, the third sonographer had completed level 1 safeguarding adults training. Laboratory staff had not received safeguarding adults training. This was not in line with the competency framework outlined in the intercollegiate document on adult safeguarding. However, administration staff had received safeguarding adults training to level 1 in line with the requirements of the intercollegiate document on adult safeguarding.

Requires Improvement

Diagnostic and screening services

Staff followed safe procedures for children visiting the service. However, not all staff had completed training on safeguarding children. The service did not provide screening appointments for children. However, children may attend the service during their parent's appointment and were not left alone by that parent. Not all staff had completed safeguarding children training. One out of four nurses had completed level 3 safeguarding children training and one nurse had completed level 2; two of the four nurses had no evidence of safeguarding children training. Two out of three sonographers had completed level 2 safeguarding children training, the third sonographer had completed level 1 safeguarding children training. Administration and laboratory staff had not completed safeguarding children training. This was not in line with the competency framework outlined in the intercollegiate document on safeguarding children.

Staff did not always know how to make a safeguarding referral and who to inform if they had concerns. The service could not be sure all safeguarding concerns were escalated appropriately. The service had a safeguarding policy, which was reviewed yearly. The safeguarding policy did not include contact details for the local safeguarding service. The service had not made a safeguarding referral in the last year. Some staff had a lack of understanding about the service's process of safeguarding referral and who to go to if they had concerns. However, other staff gave examples about protecting patients, which were relevant to the service. For example, they described a scenario where an elderly patient came in with their carer and staff discovered signs of physical harm or psychological harm. Staff described that they would immediately report this to the manager who would then investigate.

Cleanliness, infection control and hygiene

Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean; however, the service could not be sure all areas were cleaned regularly.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. However, the service did not have comprehensive cleaning records to demonstrate that all areas were cleaned regularly. The service had policies on infection control and decontamination of medical devices, which were in date and version controlled. The clinic rooms, waiting area and toilet were visibly clean. Records showed nurses and sonographers completed basic cleaning of their clinic rooms each day which included removing clinical waste, wiping down the sink and wiping the ultrasound probe with antibacterial wipes. The service had a service level agreement with a cleaning company to clean the premises. However, the service did not have records to show what the cleaning staff cleaned and when.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff cleaned equipment after patient contact. The service had policies on PPE and hand hygiene, these were in date and version controlled. Staff followed these polices; for example, staff were bare below the elbows, washed hands before patient contact, cleaned equipment after patient contact and wore appropriate PPE.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. However, staff did not complete regular quality assurance checks. The service did not have a formalised record to show staff were trained to use equipment.

The service had suitable facilities and the design of the environment followed national guidance. The service was easy to find and access. The service was within a GP practice and on the first floor with lift access. The service had a light airy waiting room with plenty of seating for patients to wait for their appointment.

Requires Improvement

Diagnostic and screening services

The service had enough suitable equipment to help them to safely care for patients. Staff carried out daily safety checks of specialist equipment. The nurse consultation room had an electrocardiogram (ECG) machine, blood pressure machine and scales. The service had agreements with a company who completed yearly calibration and servicing checks on the nursing equipment, which were all in date. The service had agreements with the manufacturer of the ultrasound machine who serviced the machine yearly and this was in date.

Sonographers completed daily quality assurance and safety checks of the ultrasound machine such as crystal drop out, plug damage and sparking. These checks were in line with level 1 and 2 of BMUS guidelines for the regular quality assurance testing of ultrasound scanners by sonographers. However, staff did not complete regular quality assurance checks of the ultrasound machine in line with Level 3 BMUS guidelines. The service relied on the yearly quality assurance checks completed by the manufacturer and therefore ultrasound scanning quality might not always be accurate.

There was no evidence to show staff were trained to use equipment. The service had a training agreement with the manufacturer of the ultrasound machine; however, the service did not have evidence staff had completed this training and therefore could not be sure staff were using ultrasound equipment safely. During induction, staff observed use of equipment and were supervised using equipment during their first few screening sessions. However, the service did not have a formalised record to assure themselves that staff had been trained to use equipment.

Staff disposed of clinical waste safely. Waste was segregated with separate colour coded arrangements for general waste and clinical waste. Sharps, such as needles, were disposed of correctly in line with national guidance. The service had service level agreements with a disposal service to remove clinical waste and sharps from locked bins outside the service.

Assessing and responding to patient risk

The service did not complete risk assessments for each patient as this was not relevant to their service.

Staffing

The service had enough staff to keep patients safe from avoidable harm and to provide health screening.

The service had enough staff to keep patients safe. Managers did not use bank and agency staff. The service had four nurses, three sonographers, two laboratory staff and three administration staff. The service did use bank or agency staff as they felt continuity of care was better achieved with consistent staff. If staff were sick at short notice, managers aimed to get other staff to cover the shift.

The service had a lone working policy, staff sometimes worked alone but staff had an understanding of the policy and their responsibilities.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Records were stored securely. All records were stored in the services online system and were protected with individual passwords. The online system held individual patient records which were comprehensive and complete.

Requires Improvement

Diagnostic and screening services

Medicines

The service did not prescribe, administer, record and store medicines as this was not part of the service.

Due to the nature of the service delivered, the service did not offer advice on medicines or prescribe them. The service did not store medicines on site.

Incidents

Staff recognised incidents and near misses and reported them appropriately. Managers did not always investigate incidents and share lessons learned with the whole team. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

Not all staff understood the duty of candour. The service could not be assured that staff were being open and transparent when things went wrong. Two out of three staff we spoke with had a lack of understanding about duty of candour and how it applied to their role. This service had a duty of candour policy, but the policy lacked a clear definition of duty of candour.

Managers did not always investigate incidents thoroughly. The service had one incident reported in the last 12 months; the incident had not been investigated. This was not in line with the service's policy and meant the service could not be assured relevant learning actions had been identified and acted upon to improve patient care and safety.

The service cannot be assured learning actions from alerts were implemented to improve patient safety. The service did not have arrangements to review or respond to external patient safety alerts, recalls, inquiries, investigations or reviews.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents in line with the service's policy. The service had an incident policy which was in date and version controlled. The service had one incident in the last 12 months; staff reported this in line with the service's policy. Staff had a good understanding of what incidents might occur and how to report them using the online system.

Staff told us they would receive feedback from investigation of incidents and would meet to discuss the feedback and look at improvements to patient care. Managers debriefed and supported staff after any serious incident. Staff had opportunities during team meetings to discuss incidents and share learning from feedback but there was no recorded discussion of the incident that had occurred in the past year. Following a distressing incident, staff said the service held a debrief to support staff and identify improvements.

Are Diagnostic and screening services effective?

Inspected but not rated

We do not rate effective for this service.

Requires Improvement

Diagnostic and screening services

Evidence-based care and treatment

The services provided were based on national guidance and evidence-based practice. However, the service did not check to make sure staff followed guidance.

Staff followed up-to-date policies to deliver high quality health screening according to national guidance. The service had agreed processes for their screening services, which were reviewed on a regular basis against national guidance. For example, the service identified a need for GP referral screenings which showed fatty livers, in line with the National Institute for Health and Care Excellence (NICE) guidance. The service held discussions with GPs to review their referral practice regarding fatty liver observations, to ensure a linked in approach.

However, the service did not check to make sure staff followed guidance. The service did not have a systematic programme of clinical and internal audit to monitor quality and the service did not have systems to identify where action should be taken.

Nutrition and hydration

Staff gave patients enough drink to meet their needs.

Staff made sure patients had enough to drink. Patients did not attend the service for longer than a couple of hours for their appointments. The service provided hot drinks and water as needed.

Pain relief

The service did not assess patients for pain, give pain relief, or advice.

Due to the nature of the service, patients did not have chronic pain, therefore the service did not assess pain.

Patient outcomes

Staff monitored patient outcomes; they used the findings to make improvements. The service had not been accredited under relevant clinical accreditation schemes.

Managers and staff used the results to improve patients' outcomes. The service routinely monitored the number of their screening appointments which resulted in a GP referral. The service used this information to improve the service. For example, the service identified the most common test result referred to GPs was the bowel test and were considering how to improve the bowel test process.

Sonographers peer reviewed image reports against British Medical Ultrasound Society (BMUS) guidelines monthly. The service recorded findings and identified actions to address where there were problems. Managers ensured learning actions were shared by email or during team meetings.

However, the service was not accredited by the United Kingdom Accreditation Service (UKAS). The service did not formally review their services against the Quality Standard for Imaging (QSI) and was not independently assessed against these standards by UKAS.

Competent staff

The service did not make sure staff were competent for their roles. Managers appraised staff's work, but these were overdue. The service did not complete clinical supervision with staff.

The service could not be sure staff had the right skills and knowledge. The service could not be sure staff had the right skills and knowledge to carry out screening on patients. New staff started by observing screening clinics carried out by another nurse, staff were then observed screening patients. This was to check their competency to screen and complete reports. However, the service did not have formalised competency assessments to show that nurses, sonographers and laboratory technicians were competent to carry out their roles.

Requires Improvement

Diagnostic and screening services

The service did not complete clinical supervision with staff. The service did not identify where staff had gaps in their clinical practice and offer the opportunity to develop these skills. A nurse held regular clinical supervision, but the service did not have records to show it was completed.

Managers supported staff to develop through yearly, constructive appraisals of their work, however these were overdue. The service aimed to complete structured appraisals yearly; however, all staff were overdue for their yearly appraisal. The manager had a plan to complete all the staff appraisals in the next month.

The manager told us staff received appraisals as part of their substantive employment. However, the service did not have reciprocal arrangements to share results of appraisals with substantive employers.

The manager did not always identify training needs for their staff, but the manager gave them the time and opportunity to develop their knowledge. Staff had the opportunity to discuss training needs with their line manager every two weeks and during their annual appraisal and were supported to develop their skills and knowledge. The service gave staff protected time to complete training to improve their knowledge.

Managers identified poor staff performance promptly and supported staff to improve. The service had a proactive process to identify and investigate poor performance within the service, but this had not been needed.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The service held minutes of team meetings to outline the discussion. Meeting minutes were clear, complete and easily accessible to staff if they had not been able to attend a meeting.

Managers gave all new staff a full induction tailored to their role before they started work. The service had structured induction checklists tailored to each staff role. Staff responsible for supervising induction completed these. We saw completed induction checklists.

Staff had relevant professional registration. Nursing staff were registered with the Nursing and Midwifery Council (NMC) and sonographers with the Health and Care Professions Council (HCPC).

Multidisciplinary working

Sonographers, nurses and laboratory technicians worked together as a team to benefit patients. They supported each other to provide good advice.

Staff regularly discussed patients to join up working and improve patient advice based on their screening results. The service operated a red card flag system when the sonographers saw something suspicious during the ultrasound screening. This flagged the patient to the laboratory technicians so they could prioritise that patient's results and check for factors which could explain the suspicious images on the ultrasound. For example, the sonographer might observe a fatty liver which was confirmed by blood test results; the results are highlighted to the nurse and relevant advice based on the ultrasound and blood tests provided in the patient's results letter.

Patients could see all the health professionals involved in their care at one-stop clinics. The service offered nurse screening and ultrasound screening appointments on the same day for patients to attend.

Staff kept GPs informed when required to follow-up on patients. The service sent patients GPs screening results, when the patient consented for them to do so. The service proactively spoke with GPs and answered questions they had about patients' test results.

Requires Improvement

Diagnostic and screening services

Seven-day services

Key services were available five days a week.

The service offered a nurse screening clinic five days a week. The service offered an ultrasound screening clinic run by a sonographer four days a week on Monday, Tuesday, Wednesday and Friday. The clinics ran between 8:30 to 5:00. The service did not run at weekends.

Health promotion

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

Staff assessed each patient's health at every nurse screening and provided support for any individual needs to live a healthier lifestyle. The service asked patients to fill out a health questionnaire before their screening appointment, this enabled staff to have structured conversations and offer patients health and wellbeing advice based on their lifestyle risk factors. For example, if the patient indicated their alcohol intake was over the recommended weekly amount, the nurse recommended ways to reduce this.

The service supported national priorities to improve patient's health. For example, the service offered advice and signposted to support services on quitting smoking, obesity and cancer.

The service had relevant information promoting healthy lifestyles and support in patient areas. The service had posters in the waiting area and clinic rooms to promote a healthy lifestyle. Following screening, the nurse sent out results to the patient and included relevant leaflets to empower the patient to manage their own health and wellbeing, where results showed they needed improvement.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

The service gained consent from patients for their screening in line with legislation and guidance. The service made sure patients consented to screening based on all the information available. Consent was clearly recorded in the patients' electronic records. When patients were offered an appointment, they were sent information about the screening, including what to expect and what the tests entailed. The service asked for consent electronically before the patient completed the health questionnaire. Consent was recorded in the patient's electronic record.

The service had a policy on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005 and they knew who to contact for advice. The service had a Mental Capacity Act policy, which was in date and version controlled. The policy described the service's process for patient consent and processes for clinical staff to follow if they suspected a patient might not have capacity. For example, staff explained the screening and the tests and asked the patient to repeat the information. The clinical staff decided if the patient understood information about the tests, retained the information and had the ability to evaluate the information. If this was not the case, staff did not carry out the patient's screening appointment. Staff could ask for advice from the manager if required.

Nurses and sonographers received training in the Mental Capacity Act and Deprivation of Liberty Safeguards, however they did not always complete it. The service could not be sure staff had knowledge and understanding around Mental Capacity Act and Deprivation of Liberty Safeguards. Three of the four nurses had completed Mental Capacity Act training. Two of the four nurses had completed Deprivation of Liberty Safeguards training. Two of the three sonographers had completed Mental Capacity Act training. One of the three sonographers had completed Deprivation of Liberty Safeguards training.

Requires Improvement

Diagnostic and screening services

Are Diagnostic and screening services caring?

Good

Caring had not previously been rated. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when screening for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. The service offered longer appointment times for screening, this meant staff had time to interact with patients and build trust. Staff spoke with patients in a caring, non-judgmental, understanding and respectful way.

Patients said staff treated them well and with kindness. The service sent patient feedback forms following appointments. In feedback forms in the last month, all respondents answered yes to the question "The clinical team made me feel comfortable" and "The clinical team were professional, knowledgeable and friendly".

Staff followed policy to keep patient care and treatment confidential. Staff ensured doors to the clinic rooms were closed when screening appointments took place, this ensured privacy and dignity and meant that conversations were not overheard.

Staff understood and respected the personal, cultural and religious needs of patients and how they may relate to their health. Screening appointments were individualised based on patient answers to their health and well-being questionnaire. The questionnaire gave opportunity for patient to comment on personal, cultural and religious needs; which staff said they considered. However, the service did not have a chaperone policy and staff did not know when a chaperone would be appropriate. This was not in line with the BMUS guidelines.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff demonstrated empathy when having difficult conversations. Sonographers took time to explain what they were seeing during the ultrasound with the patient. If something on the ultrasound was suspicious, sonographers would describe this to the patient with empathy and in a way they understood. Staff informed the patient of the next steps and when to expect the ultrasound and nurse's report. Staff understood that if they discussed suspicious findings with the patient, it could be distressing for them. Staff supported patients and encouraged them to follow up with their GP. The service rung the patient within a month to check if the patient had been in contact with their GP.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand the outcome of their screening.

Staff made sure patients and those close to them understood their screening. Staff talked with patients, families and carers in a way they could understand. The service provided appointments which lasted 45 minutes, patients had time to ask questions and understand health advice given. Staff communicated with patients in a way they could understand, for example avoiding the use of medical jargon and staff checked patients understood the information. The service was person-centred and met the need of the patient as advice given during the nurse screening appointment was guided by patient answers in their health and well-being questionnaire

Requires Improvement

Diagnostic and screening services

Staff supported patients to make informed decisions about their lifestyle. Staff took time to discuss the patient's lifestyle with them during their nurse screening appointment. The nurse offered advice and signposted the patient to information support them to make informed decisions about their wellbeing and lifestyle. Following the appointment, the service produced a booklet which was send to the patient; this included health tips, an action plan and signposting to websites to support them make informed decisions.

Patients and their families could give feedback on the service. Patients gave positive feedback about the service. The service asked for feedback via email through an online survey following the patient's appointment. Patient surveys demonstrated consistently positive feedback from patients.

Are Diagnostic and screening services responsive?

Good

Responsive had not previously been rated. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and organised services so they met the needs of the local population.

The service had been planned to meet the needs of the local population; for example, patients accessed the service through a self-referral to obtain health advice and screening. This is allowed patients to make healthy choices and seek early referral in case of emerging health concerns. The service supports local GP's and the NHS in this health prevention work. The service is accessible for all adults as payment was voluntary and based on financial affordability to pay.

Facilities and premises were appropriate for the services being delivered. The service location was easy to find and accessible. The service did not have parking for patients but recommended parking at the local supermarket. The service had plenty of seating in the waiting area

The service emailed appointment instructions to the patient prior to the appointment, this information was in an accessible format. Information included preparation for the screening appointments and logistics such as how to find the service and where to park. Patients received sample collection kits in the post with easy to read instructions.

Staff monitored and took action to minimise missed appointments. Staff ensured that patients who did not attend appointments were contacted. The service recorded when patients missed their appointment. Staff phoned patients and asked if they would like to rebook. The service minimised missed appointments by sending reminders leading up to the appointment.

Requires Improvement

Diagnostic and screening services

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

The service minimised the number of times patients needed to attend the service, by ensuring patients had access to the required staff and tests on one occasion. If a patient was travelling from outside the local area the service ensured the nurse screening appointment and the ultrasound screening appointment were on the same day. The service offered local patients the choice of attending both screening appointments on the same day or on different days. The service explained that if they were seen on different days, the service may see them more quickly.

The service had systems to help care for patients in need of additional communication support. Managers made sure staff and patients could get help from interpreters or signers when needed. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service identified patients who required additional communication support and created an alert on the patient record which all staff would see when they accessed the patient record. The service had access to communication support services such as translation and interpretation, audio and braille support was accessed if needed. The service sent easy read and large print screening reports and letters on request. The service provided information which met NHS England Accessible Information Standard; for example, they had an easy read complaints document on their website.

Access and flow

People could access the service when they needed it and received the right care promptly.

Managers monitored waiting times. Patients were generally well and self-referred to the service. There was a wait time of around three months for an appointment which was communicated to patients. The service offered a choice of appointments at the time of booking. Patients who lived locally were added to a list where they agreed to be contacted if a last-minute appointment became available. This helped reduce the waiting list. The service monitored waiting times for patients when they attended and generally ran on time. Patients were kept informed about disruptions.

After their appointment, patients received a nurse and sonographer report sent by post the next week once all the test results had been received. The service sent a report to the patients GP by post. The service contacted the GP to check they had received the reports.

The service monitored did not attend rates. The service had very few patients who did not attend their appointment. The service reported did not attend rates to the trustees in a monthly board report.

Managers worked to keep the number of cancelled appointments to a minimum. When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible. The service had low number of cancelled appointments. When necessary, the service contacted each patient to explain why they were cancelling their appointment and rebooked the patient at the next available appointment.

Learning from complaints and concerns

The service treated concerns and complaints seriously. The service told us they investigated complaints and shared lessons learned with all staff. It was easy for people to give feedback and raise concerns about care received, however the service did not clearly display information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. The service had a complaints policy which was version controlled and in date. The service had not received complaints in the last year so we could not check staff followed this policy, but staff described their responsibilities in line with it.

Requires Improvement

Diagnostic and screening services

Staff knew how to acknowledge complaints and patients would receive feedback from managers after the investigation into their complaint. On receipt staff logged the complaint and provided an initial response within three working days, which provided timescales for the full response. Following investigation, the patient received feedback and the service told them what had been done in response. The service outlined next steps if the patient was not happy with the response, this involved investigation by the Chief Executive Officer (CEO) and then, if still not resolved, investigation by a trustee. The service did not provide independent resolution of complaints.

Managers share feedback from complaints with staff and learning would be used to improve the service. The manager told us they would share complaints and feedback during team meetings to ensure learning was shared.

The service did not clearly display information about how to raise a concern in patient areas. However, the service had information on their website; this included an easy read complaints procedure leaflet. It was easy for patients to make a complaint, they could do this verbally at the time or by writing, email or telephone after the appointment.

Are Diagnostic and screening services well-led?

Requires Improvement

Well-led had not been previously rated. We rated it as requires improvement.

Leadership

Leaders had the experience and integrity to run the service but did not always demonstrate skills to implement governance and oversight processes to provide assurance of the safety of the service. The service did not have formalised processes to support staff to develop their skills and take on more senior roles. However, leaders understood and managed sustainability issues the service faced. The manager was visible and approachable in the service for staff.

Leaders had the experience and integrity to run the service but did not always have the skills and knowledge to demonstrate assurance, governance and oversight of the safety of the service. The registered manager had been the registered manager for the service since April 2020. The registered manager was also the Chief Executive Officer (CEO) responsible for running the screening service and managing the charity function of the business. The registered manager did not implement assurance processes to demonstrate that the service was safe. For example, the service did not have systems to provide regular assurance that staff were competent for their roles and performing them safely.

The service did not have formalised ways to support staff to develop their skills and take on more senior roles. The service did not have a leadership strategy or development programme. There was no formal approach to succession planning.

However, leaders understood the challenges sustainability and identified actions to address them. For example, during the pandemic the service had identified a financial risk relating to unexpected costs associated with additional PPE requirements. The service took action to stabilise their funding.

Staff said the manger was visible and approachable. The manager was not always present at the service, but staff said she was always accessible via phone or email. Staff consistently said the manager was supportive.

Requires Improvement

Diagnostic and screening services

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The strategy was focused on sustainability of services. Leaders understood and knew how to apply them and monitor progress.

The service had a business review and report which outlined the services key objectives. Objectives were focused on sustainability and quality. They included providing quality health screening, operating a service to best practice standards and to optimising costs whilst not sacrificing quality standards Progress against delivery of the strategy was monitored and reviewed during quarterly board meetings.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where staff could raise concerns without fear.

Staff felt supported, respected, and proud to work for the service. Staff told us they were proud to work there as the culture centred on the experience of patients which meant they could provide a person-centred service.

Staff had a process to ensure the safety and wellbeing of staff; for example, all staff had a COVID-19 risk assessment to assess staff's safety working in the service during the pandemic. Staff told us the service were supportive and proactive when staff suffered health issues.

Equality and diversity was promoted within and beyond the service. The service's policies did not discriminate against individuals. All clinical staff had completed equality, diversity and human rights training. All staff felt they are treated equitably and fairly, and the service provided opportunities for career development. For example, the service had offered career opportunities for when the service moved to the planned new site.

The service had a small team and all staff said the culture encouraged openness and honesty at all levels. The manager made sure staff understood the importance of being able to raise concerns without fear of retribution. The service had a whistleblowing policy, but this did not have a review date or version control, which is not best practice.

Governance

Leaders did not operate effective governance processes throughout the whole service. The service did not complete all recruitment checks in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service did not have effective assurance processes and systems to support the delivery of the strategy of good quality services. However, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet and discuss concerns.

The service did not have effective governance processes to ensure all staff were proper persons. The service did not complete all recruitment checks in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the time of inspection, the service did not hold a Disclosure and Barring Service (DBS) certificate for the service for six of thirteen staff records we looked at. Since our inspection the service had applied for all missing DBS certificates; which have all been received.

The service did not have effective assurance processes and systems to support the delivery of the strategy of good quality services. The service did not have assurance systems to support safe services. For example, the service did not

have assurance that all staff had been trained and were competent to use equipment safely. The service did not have assurance that the third party provider had completed cleaning, nor did they complete a regular cleaning audit to demonstrate compliance. The service did not carry out a regular audit schedule to demonstrate that elements of the service provided was of good quality and safe.

However, the service held meetings within specific staff groups, for example nurses, sonographers and administration staff. Issues for escalation were discussed during the monthly management operations committee with the manager and the trustees. Staff at all levels were clear about their roles and understood what they were accountable for, and to whom. Staff had regular opportunities to discuss concerns during one-to-one meetings every two weeks and team meetings every month.

The service had service level agreements with third parties for their cleaning, clinical waste removal and Faecal Immunochemical Test (FIT) testing with a local NHS trust. Service level arrangements were reviewed every two years.

Management of risk, issues and performance

Leaders and teams used systems to manage risk and performance and identified actions to reduce their impact. They had plans to cope with unexpected events. However, the service did not always identify all relevant risks.

The service had arrangements for identifying, recording and managing risks. The service had a risk register matrix which recorded the potential risk impact of the issue and recorded mitigating actions. There was an alignment between risks recorded on the risk register matrix and what staff were worried about. For example, staff told us they felt funding was a risk the service had this on their risk register matrix and had mitigating actions including an “ambitious programme of grant applications in place”. However, the service did not have robust assurance systems and therefore the service did not have oversight and identify all relevant risks. For example, the service did not review external patient safety alerts, recalls, inquiries, investigations or reviews. This meant the service may be unaware of risks associated with their equipment.

The service had plans to cope with unexpected events. For example, the service had plans and actions in preparation for further COVID-19 infection rate surges.

The service had processes to manage current and future performance and performance issues were escalated appropriately through clear structures and processes. The service recorded and reviewed the number of screening appointments completed and the number of patients who did not attend appointments. These results were monitored against targets and reported to the board.

Information Management

The service did not always collect information and analyse it to understand performance, make decisions and improvements. However, information systems were integrated and secure.

The service did not have a holistic understanding of performance, which sufficiently covered and integrated people’s views with information on quality. The service collected people’s views through feedback forms. The service measured quality of ultrasound screening through peer review audits. The service had a limited systematic programme of clinical and internal audit to monitor quality and the service did not have systems to identify where action should be taken. The service told us they completed regular hand hygiene audits and regular internal clinical audits. Following our inspection, the provider sent us evidence of these audits. However, these were for two members of staff in the same month; this did not demonstrate a systematic programme of clinical and internal audit. The service completed an infection control audit however, there was no consolidated scoring to indicate compliance and there were no associated protocols to detail the process for learning from audit results.

Requires Improvement

Diagnostic and screening services

However, the service had arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards. The service had individual log-in details, with password access to confidential personal information. Only staff who needed access to confidential personal information had access. The service had not had a data breach in the last year.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to manage services.

The service received patient feedback through feedback forms following their screening appointment. Patient views are gathered and reviewed, when areas for improvement were identified the service acted on them. The service engaged with the public during fundraising events and through contact forms on their website.

The service actively engaged with staff during staff meetings. Service developments were discussed, and staff were given opportunities to present their views about planning of the service. The service gathered staff views during the last year through health and wellbeing questionnaires and one-to-one meetings with the registered manager. Staff views were formally recorded.

Some staff did not always report positive relationships with external partners and some staff said they did not feel respected by the local healthcare community. However, the service had made attempts to create collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population. For example, the service had engaged with local GPs to understand their pathways following a referral about liver blood test results; this was to improve the way the service was managed to ensure it matched GP expectations.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Staff in the service had recently been directly involved in working with the designers of the services electronic record system to develop a bespoke system to meet the specific needs of the staff.

The service was moving to a new, larger premises later in the year. This will enable the service to expand availability of appointments improving the waiting times.

The service was investing in a marketing project around a corporate sponsorship initiative. This will mean creating contacts with local businesses, who will support a two year sponsorship package. The package allows businesses to offer their staff health screening through the service, whilst also sponsoring free outreach health screening to communities from deprived areas.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must ensure they have systems and processes to assess, monitor and improve the quality and safety of the service. (Regulation 17(2)(a))

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed • The service must ensure that they maintain compliance with mandatory training for all staff. (Regulation 19(1)(b)) • The service must ensure recruitment procedures are robust to provide assurance that persons employed meet Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Regulation 19(2))

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • The service must ensure that they maintain compliance with safeguarding mandatory training at the appropriate level. (Regulation 13(2))