Mediscan Diagnostic Services Limited

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

Mediscan Diagnostic Services Limited is operated by Mediscan Diagnostics Services Ltd. The location has been registered to deliver diagnostic and screening procedure services since June 2013.

The location, which is also the provider's head office, is the call centre, administrative and managerial centre from which the provider's national diagnostic imaging

Summary of findings

services are managed. The provider delivers a range of services including ultrasound scanning and magnetic resonance imaging scanning, which are regulated by CQC. The location does not host any clinics on site.

We inspected this service using our comprehensive inspection methodology. We carried out a short-announced inspection between 22 and 24 October 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

We have not previously rated this service. We rated it as **Good** overall, because:

- Safe care and treatment was provided by staff that had received mandatory and safeguarding training appropriate to their roles. Staff were aware of how to raise safeguarding concerns, and appropriately assessed, responded to and recorded any relevant patient risks. Staff followed infection control protocols and equipment was appropriately cleaned. There were sufficient staff, who worked flexibly, to meet the needs of the service. Staff knew how to recognise and report incidents.
- Staff provided effective care in line with evidence-based practice, national and professional guidelines. Staff were appropriately qualified and had the skills and knowledge to undertake their roles effectively. They understood the need for consent and made adjustments for patients who required additional support. The provider monitored its clinical outcomes and used these to improve its services.
- Care was delivered by staff who were compassionate and helped to maintain people's privacy and dignity. Staff supported their patients, and took time to fully explain the procedures being carried out and gave people time to ask questions.
- The provider continually assessed demand at its clinics, and planned its services to meet the needs of the local population. Staff took account of individual patient's needs, including those who needed additional support or who were living with mental health conditions or learning disabilities. Clinics were planned flexibly to meet patient need, and patients were given a choice of appointments. Complaints were taken seriously, reviewed in the clinical governance meetings and learning was shared with staff.
- The provider's leaders had the appropriate skills and knowledge to lead the service, and they had a vision and plans in place for future development of the service. Leaders could describe the potential risks to the service, and these were appropriately reviewed through the clinical governance and information governance committees. The service engaged well with patients and with referrers and there supported a culture of continual learning and improvement.

However, we also found the following issues that the service provider needs to improve:

- The provider's risk register scored and mitigated, but did not define, the impact of each identified risk.
- There were some limited gaps in the provider's documentary recruitment evidence for consistent compliance against its recruitment policy.

Following this inspection, we told the provider that it should make some improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Ellen Armistead

Summary of findings

Deputy Chief Inspector of Hospitals North

Summary of findings

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Good

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Services we looked at
Diagnostic imaging.

Summary of this inspection

Background to Mediscan Diagnostic Services Limited

Mediscan Diagnostic Services Limited is operated by Mediscan Diagnostics Services Ltd. The provider is registered to deliver diagnostic and screening procedure services.

The location is the administrative and managerial centre from which the provider's national diagnostic imaging services are managed. The location does not host any clinics on site. However, the provider manages its range of services including ultrasound scanning and magnetic resonance imaging scanning which are regulated by CQC from the location.

The provider delivers ultrasound scanning at satellite clinics in Greater Manchester, West Yorkshire, Lincolnshire, Nottinghamshire, Staffordshire and London. The provider delivers magnetic resonance image scanning services in Greater Manchester in partnership with a third party healthcare provider.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,and one other CQC inspector. The inspection team was overseen by Nicholas Smith, Head of Hospital Inspection.

Information about Mediscan Diagnostic Services Limited

The location manages the provision of diagnostic imaging services. It is registered to provide the following regulated activities:

- Diagnostic and screening procedures.

During our visit, we inspected the facilities. We spoke with a range of staff including the chief executive and senior leadership team, a sonographer and healthcare assistant, administration and reception staff. We spoke with four patients and two carers, and reviewed four sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The service has not been previously inspected.

Activity

In the financial year of 2017/18, the provider carried out 78,723 ultrasound scans and reported on 28 magnetic resonance imaging scans across all its services nationally.

Track record on safety

- No never events, serious injuries or deaths.
- No clinical incidents
- The service had no incidences of any healthcare acquired infection since opening in February 2013.

Services provided under service level agreement:

- Cleaning services
- Clinical and or non-clinical waste removal
- Maintenance of ultrasound equipment

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- 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.
- The provider had appropriate processes and procedures to manage the control of infection risk in satellite clinics.
- The location had suitable premises and equipment.
- Staff requested and recorded relevant information to assess and respond appropriately to individual patient risk. They kept clear records and asked for support when necessary.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept appropriate records of patients' care and treatment, which were clear and up-to-date.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

Are services effective?

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

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them.
- Staff had the right qualifications, skills, knowledge and experience to do their jobs.
- Staff of different kinds worked together as a team to benefit patients. Sonographers, healthcare assistants, and administrative staff supported each other to provide good care.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.

Are services caring?

Good

We rated caring as **Good** because:

Summary of this inspection

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff understood the impact that patients' care, treatment and condition had on their wellbeing, and their emotional needs.
- Staff involved patients and those close to them in decisions about their care.

Are services responsive?

Good

We rated responsive as **Good** because:

- The provider planned and provided services in a way that met the needs of local people.
- The service took account of patients' individual needs.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit to, treat and discharge patients from the service were in line with good practice.
- The provider treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Are services well-led?

Good

We rated well-led as **Good** because:

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- The provider had a vision for what it wanted to achieve and workable plans to turn it into action that encompassed staff, patients, referrers and clinical commissioning groups representing the local communities.
- Managers across the provider promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The provider used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in care would flourish.
- The provider had systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The provider collected, managed and used information well to support its activities.
- The provider engaged well with patients, staff, and local organisations to plan and manage appropriate services at its satellite clinics, and collaborated with partner organisations effectively.

Summary of this inspection

- The provider was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

However,

- The provider's risk register scored, but did not clearly define, the impact of the risks that had been identified.
- There were some limited gaps in the provider's documentary recruitment evidence for consistent compliance against its recruitment policy.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	N/A	Good	Good	Good	Good

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Good

We have not previously rated this service. We rated it as **good.**

Mandatory training

- The provider delivered mandatory training in key skills to all staff and made sure everyone completed it.
- Mandatory training was completed by staff either face to face or through an electronic learning program (e-learning). We reviewed the staff training matrix which showed full (100%) compliance by staff with all their mandatory training.
- Mandatory training modules included, although were not limited to, safeguarding vulnerable adults and children levels one and two, general data protection regulations, equality and diversity, information governance, non-clinical infection control, clinic moving and handling, dementia awareness, and awareness of Deprivation of Liberty safeguards.

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.
- The provider had a Safeguarding Vulnerable Adults Policy which had been last updated in August 2017. The provider had a Safeguarding Vulnerable Children Policy, which had been last updated in April 2018 and included links to relevant guidance documents.
- The clinical manager was the provider's safeguarding lead. The clinical manager was supported in this role by the performance manager. Both individuals had completed level three vulnerable children safeguarding training.
- All staff had completed safeguarding vulnerable children, and safeguarding vulnerable adults level two training. This was in line with intercollegiate safeguarding guidelines.
- Safeguarding level two training included modules on female genital mutilation, and safeguarding level three training included modules on child sexual exploitation and radicalisation.
- Staff we asked could describe types of incidents they would report as potential safeguarding concerns. Staff knew where to go to obtain further advice if needed.

Cleanliness, infection control and hygiene

- The location did not host any clinics or patient visits. However, the provider had appropriate processes and procedures to manage the control of infection risk in satellite clinics.
- The provider had an Infection Control Policy, which was last approved and reviewed in February 2017. The policy was supported by a waste management protocol on the management of clinical, non-clinical, and household waste.
- The provider's clinical manager was the infection prevention and control lead.
- The provider reported no incidences of healthcare acquired infections across all its services in the twelve months prior to the inspection.
- Sonography and healthcare assistant staff we spoke with were aware of the 'arms bare below the elbow' protocol, which was followed when providing care to patients at the satellite clinics.

- Staff told us they cleaned probe equipment after each use with appropriate sanitising sprays. Single-use rubber sheaths were used with transvaginal probes to reduce the risk of infection; probes were thoroughly cleaned after each use.
- The provider's business development team worked with satellite clinics and health centre management teams when agreeing contracts to ensure that the premises being used for clinics were appropriate. This included ensuring that privacy curtains, wash basins, cleaning and other appropriate infection control measures were in place.

Environment and equipment

- The location had suitable premises and equipment.
- The location consisted of three open-plan offices on the first floor of a shared use office complex. The building and the offices were accessible for people using wheelchairs and a lift was available for any visitors or staff. Shared use bathroom and kitchen facilities were available on the same floor for all tenants in the building.
- A range of administrative and managerial functions were carried out in each of the offices, with the call centre primarily occupying one of the three rooms.
- The offices were light, airy, tidy and visibly clean with a calm and relaxed atmosphere. Desk dividers reduced the amount of ambient noise and reduced the possibility of confidential patient telephone calls being overheard. A display screen in the call centre enabled managers and staff to monitor the number of calls waiting. Electrical equipment within the offices had been safety tested.
- At the time of the inspection, the provider was progressing with plans to move its operations to its other registered location in Oldham. It was expected that the move would take place as soon as associated building work in the Oldham location was complete.
- The provider had 25 ultrasound scanners. Two of these were spare machines that were available for use if other equipment was in the process of being repaired. A process was in place to ensure timely provision of spare machines to reduce any delays or cancellation of patient appointments.
- Ultrasound scanning equipment was tested and maintained through maintenance contracts with third party suppliers. We viewed the portable appliance testing logs held by the provider which confirmed that all machines more than 12 months old had been safety tested.
- The provider's maintenance manager held details of all contracts held. We reviewed the records which confirmed that equipment had been appropriately tested and maintained.
- The provider did not have its own magnetic resonance imaging equipment. Magnetic resonance imaging scanning services were undertaken through a service level agreement with a third-party provider. Scans were carried out by the third-party provider's staff at its premises. Scan images were subsequently transferred to the provider and were reported on by the provider's consultant radiologist. The provider assured itself on the safety of third-party equipment and services through the monitoring of the service agreement and the third-party's corporate health and safety policy.

Assessing and responding to patient risk

- Staff requested and recorded relevant information to assess and respond appropriately to individual patient risk. They kept clear records and asked for support when necessary.
- The Mediscan Care Pathway Protocols policy provided a framework for the receipt and processing of ultrasound and magnetic resonance imaging diagnostic referral requests, including the processes for scanning and reporting of ultrasound diagnostic reports.
- The protocols provided an urgent scanning and reporting pathway, which also facilitated the urgent report of unexpected findings.
- Urgent scan requests were processed within 24 hours. Sonographers immediately reported the outcome of urgent requests, or unexpected abnormal findings, direct to the referrer by telephone after the patient examination was complete.
- The written report for any urgent scans were prioritised by the sonographer and the reporting team for same day transmission to the referrer by NHS secure email. The reporting team subsequently checked with referrers that the report had been received.
- Where the referring clinician requested additional urgent imaging from the service, such as magnetic

resonance imaging to support referral into a secondary care provider, the service supplied the images directly to the secondary care provider using the image exchange portal.
- Sonography and healthcare assistant staff we asked were aware of the protocol and could describe the actions they would take with urgent scans and for unexpected abnormal findings.
- The provider's referral, vetting and booking guide prompted staff to request and record details from patients of any disability or mobility issues they may have. Call centre staff also provided scan-relevant preparation advice to patient when confirming the appointment.
- The provider's referral forms for magnetic resonance imaging scans clearly set out the criteria for acceptance of referrals. This excluded referrals for any patients under the age of 18; patients who had implanted medical devices which were contraindicated for magnetic resonance imaging scanning; referrals for scans on any part of the body except head, neck and cervical spine; and, patients with suspected cancer.
- All staff had undertaken basic life support training and those we asked were aware of, and were able to describe, the actions they would take to contact the emergency services immediately in the event of a patient collapse.

Staffing

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staffing was modelled by the provider for each clinic to maximise its resources and available patient appointment slots, and to fulfil the requirements of its commissioners. The provider continually assessed if staffing gaps could be filled by transfer of staff between clinics, or between regions, cross-training of staff, and in emergencies by using locum sonographers or by the provider's lead sonographer.
- The provider's chief executive, who was also a consultant radiologist and sonographer, provided cover as and when required. The chief executive reviewed and reported on all magnetic resonance images
- Due to the nature of the provider's services, sonography teams were based in or travelled to provide clinics in a number of satellite locations across the country.
- At the time of the inspection, service-wide, the provider employed 18 full-time and one part-time sonographers supported by 32 full-time and six part-time healthcare assistant staff and five full-time reporting staff.
- The provider was supported by a team of 26 administrative staff, which included customer service call centre staff. There was one administrative vacancy. A further 18 staff (inclusive of the chief executive) provided leadership, managerial, IT and business development roles in the organisation.
- At the time of the inspection, service-wide, the provider had two vacant sonographer posts, one vacant business development post, and one vacant administrative post.
- Between May and July 2018, the provider reported, service-wide, that 24 administrative shifts and seven healthcare assistant shifts had been covered by bank staff. During the same period two healthcare assistant shifts had been covered by agency staff.

Records

- Staff kept appropriate records of patients' care and treatment, which were clear and up-to-date.
- The provider had a Records Management / Health Records policy, which was last updated in February 2018. The policy set out staff responsibilities for managing records appropriately, and linked to relevant legislation and guidance.
- We reviewed five patient scan reports during our visit. All reports we viewed were clear, and included relevant information and differential diagnosis findings in line with the Standards for Reporting and Interpretation of Imaging Investigations 2006 guidelines of the Board of the Faculty of Clinical Radiology.
- All reports were checked by the reporting team before being sent to the referrer.
- Routine written reports were sent to the referrer approximately two to five days after the scan. At the time of the inspection, the reporting team was reviewing and sending reports of the previous day's scans.
- Urgent written reports were sent within 24 hours of the scan, and could be sent same day if requested. However, reporting staff and sonography staff confirmed that referrers were immediately informed of any abnormal findings by telephone.
- Where Mediscan and the referrers had access to the same shared patient information records system, reports were sent via that system. Otherwise reports were sent by NHS secure email.

- Reports and scan images were also shared, as appropriate, with secondary care healthcare providers by the image exchange portal.

Medicines

- The provider did not hold any medicines or controlled drugs.

Incidents

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.
- The provider had a serious incident policy. Incidents were reported and managed at provider-wide level in line with the policy. We saw evidence that incidents were discussed and learning was shared in the clinical governance meetings and staff meetings.
- The provider reported no never events in the twelve months prior to the inspection.
- The provider had a duty of candour policy. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- The policy set out staff responsibilities at all levels of the organisation to be open, honest and to communicate timely with patients in all incidents where the patient had been exposed to moderate or severe harm, or death.
- Staff we asked could describe the types of incidents they would report, and how they would do this. Staff were aware of how to obtain further advice on a potential incident if they were unsure.
- Incidents were reviewed and investigated by the clinical manager, and were discussed in the clinical governance meetings. Lessons from incidents were shared with staff at team meetings.
- The senior leadership team were aware of the duty of candour.

Are diagnostic imaging services effective?

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

Evidence-based care and treatment

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- The provider's policies and procedures took into account guidelines from a range of national and professional bodies. These included, although were not limited to, The British Medical Ultrasound Society Safety Statements (2007 to 2017) and The Royal College of Radiologists' Standards for interpretation and reporting of imaging investigations (March 2018).
- The provider's clinical manager was responsible for reviewing and updating the provider's policies, pathways and guidelines in line with updated national guidance. Changes to policies were agreed and ratified through the provider's clinical governance committee.
- Policy and procedure updates were subsequently shared with staff by the operations and performance managers by email and in staff meetings. A confirmation process was in place to ensure that staff read updates.
- Staff could access the policies and procedures which were stored centrally on the provider's computer system.
- We reviewed a range of policies and procedures during and after the inspection. These were in date, with version history recorded, and had been appropriately reviewed and approved.

Nutrition and hydration

- Administrative staff provided patients with preparation advice on nutrition and fluids at the appointment booking stage for the type of scan to be undertaken.

Pain relief

- The location did not hold any medicines, including pain relief medicines. Due to the nature of the scans carried out at satellite clinics, the provision of pain relief medicine was not required.
- However, staff were aware of the need to sensitively review patients' mobility levels and comfort when positioning them on the treatment table for scans. Staff members confirmed they would ask patients if they were in any pain or discomfort.

Patient outcomes

- Managers monitored the effectiveness of care and treatment and used the findings to improve them.

Good

Diagnostic imaging

- Each satellite clinic was subject to a range of key performance indicators agreed between the provider and the local clinical commissioning groups.
- There was variation in the required indicators by clinical commissioning group area. However, all but two of the areas required the provider to monitor the number of repeat scans because of incorrect or inadequately performed scans. Between July and September 2018, where this measure was monitored, the provider reported no repeat scans were required.
- Most of clinical commissioning groups required the provider to monitor a key indicator on the number of reports provided within five working days of the scan. One clinical commissioning area required the service to monitor the number of reports provided within two working days of the scan. The target for these indicators was 100%; the provider achieved this target in all areas between July and September 2018.
- All patient reports were checked by the reporting team for administrative errors and clinical discrepancies prior to being sent to the referrer.
- A blind sample of five per cent of each sonographer's reports were second-checked clinically each month for accuracy of reporting by the chief executive and lead sonographer. External auditing of magnetic resonance imaging scan reports was carried out under agreement with an independent consultant radiologist from a local NHS healthcare provider.
- For cases where the referrer raised queries or concerns about the report, the patient was given a second appointment for a further scan with the sonographer, supported by the lead sonographer. However, as noted above, no repeat scans were required between July and September 2018.
- Cases where concerns had been raised were discussed at the bi-monthly provider discrepancy meetings. The discrepancy meetings were led by the chief executive and the clinical manager and were attended by all sonographers.
- Any clinical errors were feedback to the professional involved. This was in line with the Standards for Reporting and Interpretation of Imaging Investigations 2006 guidelines of the Board of the Faculty of Clinical Radiology.

Competent staff

- Staff had the right qualifications, skills, knowledge and experience to do their jobs.
- The provider had a core induction and probationary programme which all staff, including bank and agency staff, were required to undertake prior to starting their duties. The provider held evidence of staff completion of the induction programme.
- The core induction programme covered the Mediscan vision and values; patient care; promoting equality and inclusion; review of key provider policies; communication and multi-professional working; health and safety; and a tour of all the relevant buildings.
- Clinical supervision meetings for sonography staff were held bi-monthly to discuss difficult or interesting cases. Additional supervision sessions for the whole clinical team were held as required. The provider supported additional training, observation or clinical supervision for staff where performance concerns or errors had been raised as part of the reporting discrepancy meetings.
- The provider supported clinical staff to maintain continuing professional development portfolios to meet the requirements of their respective professional bodies. This enabled staff to demonstrate evidence for revalidation purposes and when registering to become a member of the Society of Radiographers.
- The provider supported additional education for sonography staff. This included the provision of training in musculoskeletal sonography as part of the Salford University master of science diagnostic programme.
- The provider had a Staff Performance and Appraisal policy. Staff underwent yearly appraisals during which personal and professional development plans were discussed and agreed. Appraisals included an annual observed competency assessment relevant to staff member's individual areas of practice.
- Data received before the inspection included appraisal rates reported at provider level for staff that had been in post longer than 12 months. All staff groups where this applied, except for administration and sonography staff, reported a 100% appraisal completion rate. For sonography staff, 95% had received an appraisal and for administrative staff 85% had received an appraisal.
- Updated data provided after the inspection indicated that all staff in post for over 12 months had received an appraisal or had an appraisal imminently scheduled.
- The chief executive, who was a consultant radiologist, had undertaken professional revalidation with the general medical council within the last twelve months. All the provider's sonographers undertook revalidation during the same period.

Good

Diagnostic imaging

- The provider checked the professional registration and enhanced disclosure and barring service reports for its staff.

Multidisciplinary working

- Staff of different kinds worked together as a team to benefit patients. Sonographers, healthcare assistants, and administrative staff supported each other to provide good care
- Staff described a good working atmosphere, and spoke positively about working with their colleagues and managers.
- We observed effective communication and working practices between sonography and healthcare assistant staff, and with the administrative and managerial staff.
- The provider had a dedicated GP contact line which enabled referrers to raise queries with referral requests or reports.

Seven-day services

- Satellite clinic opening times varied with each clinic site across all the regions served by the provider. These included sites that supported clinics at the weekend. Patients were offered appointments and clinic locations to suit their needs.
- Staff across all the provider's satellite clinics were supported by the provider's call centre administration team which operated seven days a week between 8am and 8pm on weekdays and 8am and 4pm at the weekend.
- A separate GP enquiry line, which could be used by GPs requesting information about patient scans being undertaken was available during the same hours.

Consent and Mental Capacity Act

- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.
- The provider had a Consent to Examination and Treatment policy, which was last updated in June 2018. The policy included guidance on the assessment of capacity and completing consent forms, completion of best interests' assessments for patients that may lack capacity including a copy of consent form two. The policy was linked to relevant legislation including the Mental Capacity Act 2005.
- The provider had a Mental Capacity Act policy, which was last updated in August 2018. The policy included a record of assessment of mental capacity form.
- Verbal or implied consent was obtained before procedures were carried out. However, prior written consent from the patient was obtained for any invasive scans such as transvaginal scans. Patient's who, at the time of their appointment, refused to consent to transvaginal scans were also asked to sign a refusal section on the form.
- Staff we asked were aware of the need to obtain consent from patients before undertaking any procedure. Staff told us they would raise any concerns about a patient's capacity to consent with the clinical manager. We observed staff checking patient details and consent appropriately at the start of their procedures.
- Patients who were assessed as lacking capacity to consent were referred back to their GPs for onward referral into relevant diagnostic imaging services in secondary care settings.

Are diagnostic imaging services caring?

Good

We have not previously rated this service. We rated it as **good.**

Compassionate care

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff cared for patients in line with the provider's privacy and dignity policy, which incorporated the duty of candour. This was supported by the provider's Making Every Contact Count guidelines. We observed call centre staff speaking courteously and compassionately with patients during the appointment booking process.
- The policy set out the actions to be taken by staff to promote patients' privacy, dignity and modesty; confidentiality; and equality and diversity.
- Patients were provided with additional paper covering to maintain their dignity during scans of intimate areas.

Good

Diagnostic imaging

- Between April 2018 and September 2018, an average of 98% of patients who responded to the provider's patient satisfaction questionnaire for all its services, said they had been given privacy and treated with dignity and respect by staff.

Emotional support

- Staff understood the impact that patients' care, treatment and condition had on their wellbeing, and their emotional needs.
- Staff we spoke were aware of the importance of treating patients as individuals.
- All scans were undertaken by a sonographer supported by a healthcare assistant. This meant that all patients were effectively chaperoned.
- During the booking process patients were offered a choice of clinic, appointment time, and the gender of sonographer to undertake the scan.

Understanding and involvement of patients and those close to them

- Staff involved patients and those close to them in decisions about their care.
- All patients we spoke with, during our visit to the Oldham clinic, told us they had been provided with advice by the provider's customer service team during the appointment booking process on what to eat and drink, or to avoid, in preparation for their scans.
- We observed, with the consent of the patients, five scans. Before, during and after the scans the healthcare assistant and sonographer kept the patient informed of what to expect.
- Patients were told the likely timescales in which their referrer would receive the report.
- Between April 2018 and September 2018, 95% of patients who responded to the provider's patient satisfaction questionnaire across all the provider's services, said that the procedure had been explained to them and they felt sufficient time was provided for the scan.
- We observed call centre staff clearly explaining the available options to patients, including providing preparation advice for the procedure that would be undertaken.

Are diagnostic imaging services responsive?

Good

We have not previously rated this service. We rated it as **good.**

Service delivery to meet the needs of local people

- The provider planned and provided services in a way that met the needs of local people.
- The provider's business development team worked closely with individual GP practices and clinical commissioning groups to develop services that met the needs and demands of the patients in each area.
- The provider proactively monitored demand on its services in all regions. This enabled the provider to flexibly staff each of its satellite clinics to ensure sufficient clinical and non-clinical staff numbers and clinic capacity was available to meet the needs of local people.
- The provider accommodated routine and urgent referrals at all its satellite clinics. Demand was monitored by the provider with additional clinics being added to meet demand as necessary.
- The provider had a dedicated GP enquiry line, which enabled GPs to raise queries, to provide a quick response, or to support requests for urgent scans to be carried out.
- The provider could offer domiciliary scanning within patient's homes at referrer's request for patients who were housebound or severely disabled.
- Where the provider had access to existing shared electronic healthcare service systems, such as in Greater Manchester, scan reports were transmitted to GPs via these shared patient information system. Where shared systems were not available, scan reports were sent to GPs by secure NHS email.

Meeting people's individual needs

- The provider took account of patients' individual needs.
- Each satellite clinic was assessed by the provider's business development team when planning, agreeing and contracting services with the clinics. This included assessment and mitigation of any reasonable adjustments required to meet individuals' needs. The team were actively involved in responding to any concerns raised by host clinics.

- For example, in Oldham, access to the clinic from street level was up several steps. However, a temporary ramp to enable wheelchair access to the ground floor could be provided by staff when required.
- Referral forms prompted the referrer to identify if the patient had any disabilities that staff needed to take account of. When agreeing appointments, call centre staff clarified if patients had any additional needs or disabilities. Call centre staff informed patients of how to prepare for their scans when agreeing the appointment. This information was subsequently included in a patient information leaflet sent by the provider to the patient with confirmation of the appointment.
- Staff could access translation and interpretation services for patients whose first language was not English. The provider had multi-lingual clinical and administration staff group, which enabled effective communication for patients from diverse ethnic groups.
- The provider supported patients to have a choice of gender of the sonographer undertaking the scan.
- The provider supported patients with mental health conditions or those living with learning disabilities to bring a friend, relative or carer with them who could be present and assist the patient to understand the procedures being carried out.
- The provider carried out equality impact assessments on all its policies

Access and flow

- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit to, treat and discharge patients from, the service were in line with good practice.
- At the time of the inspection, clinics were scheduled to meet the demand for services within each area, and in agreement with the clinical commissioning groups. Weekend clinics were facilitated where there was sufficient patient demand; this provided flexibility for patients that preferred to be seen at weekends.
- The provider's business development team continually monitored demand at each clinic. This meant that additional clinics could be facilitated to cover increased demand, or clinics reduced where demand had fallen.
- The provider supported the e-Referral Service (ERS) for patients. Appointments were then agreed with the patient and confirmed on the shared patient electronic records system in areas where the service had access to such systems. All appointments were confirmed to patients by text message or by letter.
- The provider accepted online and email referrals for appointments from GPs that did not have access to the shared system.
- The provider did not have a waiting list at the time of the inspection.
- Urgent referrals were accommodated within 24 hours of the request.
- Between July 2018 and September 2018, the provider reported performance against a range of key performance indicators as required by the clinical commissioning groups. The provider met, or exceeded, its targets for most of these measures. Where metrics were not measured these were not required by the clinical commissioning groups.
- The provider exceeded its target (80%) to carry out the procedure within 10 working days of referral acceptance in all 20 commissioning group areas.
- The provider met its target (100%) to carry out the procedure within 20 working days in 15 out of the 17 commissioning group areas where this metric was measured. The remaining two areas achieved 99% compliance against this target.
- The provider met its target (less than 5%) for the percentage of patients waiting longer than 30 minutes after arrival in all 17 commissioning group areas where this metric was measured.
- The provider exceeded its target (80%) for providing a report to the referrer within two working days of the procedure in all 11 commissioning group areas where this metric was measured.
- The provider met its target (100%) for providing a report to the referrer within five working days in all 17 commissioning group areas where this metric was measured.
- Between July and September 2018, the provider did not cancel any appointments for non-clinical reasons. However, the provider reported that, between April 2017 and March 2018, it cancelled one appointment across its services. This was due to an IT issue recording the wrong date and time on the patient's appointment letter.
- The provider monitored patient 'did not attend' rates for all areas. Rates varied by area from a maximum of 11.6% in the Manchester and Heywood, Middleton and

Rochdale clinical commissioning group areas to a minimum of 0% in the Calderdale area. The provider's target for the percentage of patients who did not attend their appointments was less than 5%.

- The provider had a protocol for managing patients who did not attend their appointments. Patients who did not attend appointments were contacted within 48 hours to ascertain a reason, and were offered another appointment. Patients who did not attend the second appointment were discharged back to their original referrer. One staff member we asked told us they were aware of the potential for safeguarding implications related to repeat non-attendance.

Learning from complaints and concerns

- The provider treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- The provider had a detailed complaints policy, which was in line with the requirements of The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.
- The complaints policy was supported by a complaint pathway flowchart for staff to quickly and easily follow in handling concerns or complaints. However, we noted that the flowchart incorrectly included a step to refer patients to the Healthcare Commission prior to referral to the Health Service Ombudsman. We raised this with the provider after the inspection and immediate action was taken to update the flowchart.
- Complaints leaflets were available. These provided information about how to complain, what happens when a complaint is received, confidentiality, and when to expect a response to the complaint. The leaflet provided contact information for the Parliamentary and Health Service Ombudsman, and the Independent Complaints Advocacy service. Information about how to make a complaint was available on the provider's website.
- Between April 2018 and September 2018, the provider received eight complaints about its ultrasound service. Five of these were in the Manchester region while the remainder were in the Staffordshire region.
- Between October 2017 and October 2018, the provider did not receive any complaints in relation to its magnetic resonance imaging scanning services.
- Staff we spoke with could describe the actions they would take to record a complaint on the provider's complaint form, to inform their line manager, and to forward the form to the provider's complaints manager.
- Complaints were investigated by the complaints manager. Complaints were discussed in the provider's weekly complaints meeting and reviewed in the provider's clinical governance committee meetings.
- The service aimed to acknowledge complaints within two working days and respond within 20 working days. We reviewed six complaint files during the inspection. All but one of the complaints we reviewed were responded to within the provider's response target. We were unable to determine when the response to the remaining complaint was made as a copy of the response was not in the file.
- The provider reported that it had received 2667 compliments across all its services.

Are diagnostic imaging services well-led?

Good

We have not previously rated this service. We rated it as **good.**

Leadership

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- The provider's services at each satellite clinic were directly managed by the provider's management team. The provider's chief executive and senior radiologist was a qualified consultant radiologist with over twenty years' radiology experience. The chief executive was supported by a clinical manager with over 37 years' experience in clinical practice as a radiographer, and as a governance and safeguarding lead.
- The provider had a Fit and Proper Person's Policy, which was last updated in July 2017. The policy set out the definition of a fit and proper person; the responsibilities of the provider's board to ensure that processes and procedures were in place to ensure individuals were 'fit and proper'; and the responsibilities of the clinical manager to ensure documentary records to demonstrate 'fit and proper' were maintained and stored confidentially.

- We reviewed the records held during our inspection, and found some gaps in the documentation stored. The provider was unable to demonstrate that it held copies of the qualification certificates and occupational health questionnaires for the chief executive, the clinical manager and the finance officer, and did not hold evidence of employment history for the clinical manager. We raised this with the leadership team who told us the relevant documents would be provided and recorded. After the inspection the provider sent us evidence to confirm this had since been completed and the documents were now held on the provider's secure human resources system.
- The provider had a recruitment policy, which was last updated in September 2016. The policy set out the requirements for advertising posts, shortlisting and interviewing candidates, requesting references, and relevant legal checks that were required before a successful candidate started work.
- We reviewed a combination of 15 electronic and paper staff files and discussed the recruitment process with several staff including managerial and administrative staff. When asked, staff were not consistent in their responses about whether or not their posts were advertised in line with the provider's recruitment policy. We found some limited gaps in records held in paper files; however, the human resources manager told us they were in the process of reviewing and updating the electronic staff files to ensure copies of all relevant documents were held.

Vision and strategy

- The provider had a vision for what it wanted to achieve and workable plans to turn it into action that encompassed staff, patients, referrers and clinical commissioning groups representing the local community.
- The provider's mission statement, vision, aims and core values were set out in its annual quality account report for 2017 to 18.
- The provider's mission statement was "to be a premium healthcare provider in the UK, not solely depending on size but on patient satisfaction", with a vision to provide "healthcare without boundaries".
- The provider aimed to achieve its vision by "giving the patients and the wider population the opportunity to benefit from healthier lifestyles"; by "bringing appropriate elements of care close to home" and by "designing the services to meet the needs of the local population".
- The vision and strategy were supported by a set of five values core values of caring, safe, responsive, effective, and well-led.
- Staff we asked could describe the plans for the organisation, including growth of the business into new clinical commissioning groups areas, GP practices, and into other modalities of diagnostic and treatment services.

Culture

- Managers across the provider promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Staff at all levels, including administrative and call centre staff, spoke positively about the culture within the organisation, and support they received from their managers.
- We observed positive interactions between different staff members during our inspection.
- We saw evidence in staff meeting minutes that healthcare assistants were empowered to stop procedures being undertaken if they had any concerns.
- The provider monitored its performance against the Workforce Race Equality Standards (WRES). All independent healthcare organisations with NHS contracts worth £200,000 or more are contractually obliged to collect, report, monitor and publish their WRES data and act to ensure there is no discrimination within the workplace.
- We reviewed the provider's Workforce Race Equality Standards report for the year 2017 to 18. The report indicated a diversity ratio in the workforce of three staff from black and minority ethnic backgrounds to each staff member from a white background. The report indicated that no staff members had reported bullying, harassment or abuse in the reporting year, and that all staff indicated the employer provided equal opportunities for career progression and promotion.

Governance

- The provider used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in care would flourish.

- Governance for all the provider's services was managed at provider level. The provider's chief executive was its lead for governance and quality monitoring. The chief executive was supported in the governance role by the clinical manager.
- The provider had an extensive and detailed range of policies, procedures, and care pathways across all areas of the business both clinical and non-clinical. Policies referred to, and provided links to, relevant legislation and guidance.
- Policy and procedure documents were stored centrally on the provider's shared information system. We reviewed a range of policies during the inspection and found them to be up to date.
- Clinical governance committee meetings were held monthly. The committee was chaired by the chief executive, and attended by the lead sonographer, the administration and complaints manager, the business development manager, the performance and quality manager, the information manager and information technology lead, and the healthcare assistant lead.
- We reviewed the minutes of the June and July 2018 meetings. The standard agenda included review of complaints, incidents, updates to policies, alerts, safeguarding issues, and information governance.

Managing risks, issues and performance

- The provider had systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The provider's risk management policy was last updated in June 2018. The policy provided guidance on risk assessment, likelihood, consequences, risk grading, and risk responses. The policy linked to relevant health and safety legislation, and to NHS Improvement patient safety alerts website.
- The provider's clinical governance committee provided oversight of the risks, issues and performance for each of the satellite clinics.
- The provider had a health and safety method statement and risk register document in place which detailed managerial responsibilities for health and safety within the organisation. Leaders could describe the main elements of the risk assessments included in this document.
- The statement was supported by the provider's separate risk register, which detailed provider-wide risks including corporate, administration, clinical and equipment risks. Each risk was given a score and ranking based on the probability and potential impact of each risk. Each risk had control measures in place and a risk owner. However, although the impact of each risk was scored, the register did not include a description of the potential impacts.
- Environmental risk assessments were in place for each satellite clinic.
- The provider had a Central Alerting System Alerting policy, which was last updated in May 2017. This set out staff responsibilities for cascading patient safety alerts issued by the Medicines and Healthcare Products Regulatory Agency.
- Patient safety alerts were assessed by the clinical manager, while medical device alerts were assessed by the medical electronics manager. All alerts were subsequently reviewed by the clinical governance and risk management committees before onward cascade to relevant staff.

Managing information

- The provider collected, managed and used information well to support its activities at all its clinics.
- Patient data and appointments were managed centrally by the provider using a secure electronic record system. Patient scan images and reports were initially stored locally on the ultrasound scanner before secure encrypted transmission to the provider's central records systems.
- During the inspection, sonography staff raised concerns that several of the portable ultrasound scanners did not require the user to input a password when switching the machine on. This was demonstrated to us during the inspection and we observed that it was possible to switch the machine on and access confidential patient information stored on the machine without entering a password. Although machines were not left unattended, this posed a potential information governance risk should a machine be lost or stolen.
- We raised this with the senior leadership team who told us this was a known issue that the provider had been trying to resolve with the machine manufacturers. Following the inspection, the provider sent confirmation that the issue had been resolved for all but one of the machines; the remaining machine needed further input from the manufacturers.
- The provider had access to the shared electronic patient record system that was used within the Greater

Manchester area. This meant that reports and images could be shared securely with primary care referrers through the system. Images could also be shared directly with secondary care providers securely through an image exchange portal. Although the shared system was not used in all areas, the provider continued to assess opportunities for fully electronic working including the use of other shared systems nationally.
- Information, including patient information, was stored securely by the provider. In line with the provider's business continuity policy, processes were in place for secure back-up of information and data.

Engagement

- The provider engaged well with patients and local organisations to plan and manage appropriate services at its satellite clinics, and collaborated with partner organisations effectively.
- The provider reported quarterly on patient satisfaction survey results by clinical commissioning group area. Between 1 April 2018 and 30 September 2018, the provider reported high patient satisfaction levels in all clinical commissioning group areas (excluding Staffordshire).
- An average of 93% of the patients that responded across all areas were satisfied with the booking process; an average of 96% were satisfied that the scan was conducted within 30 minutes; an average of 95% were satisfied that the procedure had been explained and they were given enough time for the scan; an average of 97% said they were given privacy; and, and average of 97% said they were shown dignity and respect. (Source: Post-inspection data request DR6)
- The provider reported its patient satisfaction results for Staffordshire for the period from September 2017 to September 2018. Of the patients that responded 83% were satisfied with the booking process; 93% were satisfied that the scan was conducted within 30 minutes and that the procedure had been explained and they were given enough time for the scan; and, 100% said they were given privacy, dignity and respect. (Source: Post-inspection data request DR6)
- The provider participated in the NHS Friends and Family test. Data provided for each of the areas varied between data for both quarters one and two of 2018/19 and only quarter two of 2018/19. However, all areas scored high for the number of patients who were extremely likely or likely to recommend the provider's services.
- Bradford (Quarter 1 & 2) 99%; Huddersfield (Quarter 2) 98%; Lincolnshire (Quarter 2) 99.6%; Manchester (Quarter 1 & 2) 99.7%; Nottingham (Quarter 1 & 2) 98%; Staffordshire (Quarter 2) 93%; Wakefield (Quarter 1 & 2) 99.6%; and, Walsall (Quarter 1 & 2) 99.7%. (Source Post-inspection data request DR6)
- Between October 2017 and October 2018, the provider achieved a 100% extremely likely or likely to recommend response for its magnetic resonance imaging scanning service.
- The provider also undertook GP/referrer satisfaction surveys. Between July and September 2018, 94% of all respondents were satisfied or fully satisfied with the quality of reports and overall experience, and all respondents were satisfied or fully satisfied with the providers responsiveness to queries.

Learning, continuous improvement and innovation

- The provider was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.
- The provider was registered with the United Kingdom Accreditation Service and was working toward achieving accreditation by the Imaging Services Accreditation Scheme developed by the Royal College of Radiologists and the College of Radiographers.
- The provider had recently invested in the installation of the picture archiving and communication system to facilitate image reporting across its services nationally.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should consider how it can clearly define the impact of risks recorded on its risk register.
- The provider should ensure that it securely maintains records to evidence consistent compliance with its recruitment policy.