Mediscan Diagnostic Services Ltd

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Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services 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

Our rating of this location improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and had implemented systems to manage safety. Staff completed and documented patient risk assessments. The service had established appropriate systems and processes to improve control of infection risk. Staff kept care records. The service had implemented systems for managing safety incidents and learned lessons from them.
- Staff provided good care and treatment and gave patients enough to drink. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available to suit patients' needs.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care 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 treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. Staff were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged with patients to plan and manage services and all staff were committed to improving services continually. The service made it easy for people to give feedback about treatment and care

However:

- There was some inconsistency in the correct identification of ultrasound equipment units seen at the satellite clinic and recorded in the service's equipment asset registers.
- Audit processes had been implemented for safeguarding, IPC and equipment checking but outcomes were not yet fully embedded due to the limited clinical activities at the time of inspection.
- Electronic systems used for patients having transvaginal or invasive scans did not allow patients to directly record their consent and this practice was not consistent with the service policy.
- The service did not have a process for applying 'pause and check' guidance from the British Medical Ultrasound Society for relevant scan procedures.
- Wider service risks were not always clearly considered or identified in risk registers and there was duplication between the quality improvement action plan and the risk register.
- The service did not have a documented strategy or vision although staff were broadly aware of the organisation's values.
- Governance and risk management systems were not yet fully embedded due to the limited levels of clinical activity in the service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Good 	Our rating of this service improved. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Mediscan Diagnostic Services Limited

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

The provider delivers a range of services including primarily ultrasound scanning, also some audiology services and physiotherapy which are not regulated by CQC. The location does not host any clinics on site, providing satellite clinics hosted in GP surgeries, private clinic buildings and hospitals. Prior to inspection in April 2021, Mediscan Diagnostics Services Ltd ran between 99 and 130 satellite locations from these sites.

Following inspections in April and June 2021 we imposed conditions on the provider's registration which limited the practice of invasive ultrasound procedures, including endoscopy, colonoscopy, sigmoidoscopy and trans-vaginal scans. Following our review at inspection in March 2022 of the provider's actions in response to the identified concerns, the conditions have now been removed.

Between April 2021 and March 2022, we have carried out five inspections. The latest inspection in March 2022 was to review the actions taken to improve after Warning Notices were issued for failure to comply with the requirements of Regulation 12 Safe Care and Treatment and Regulation 17 Good governance.

At the last inspection in March 2022 we reviewed evidence to support the provider's actions to improve, following the breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 we had also previously identified at the November 2021 inspection. These included Regulations 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors; Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment; Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment; and Regulation 18 HSCA (RA) Regulations 2014 Staffing.

At the last inspection of the service in March 2022 we rated the service as Requires Improvement.

How we carried out this inspection

We carried out an unannounced comprehensive inspection of the diagnostic and screening core service on 21 and 22 June 2022. During our inspection we visited the main location and a satellite clinic at Ashton under Lyne. At the time of inspection, following a period of suspension in 2021, the service was continuing with a limited scope of service, having seen twenty private patients to date and beginning to deliver services from their satellite clinics in Ashton and at two London locations.

We inspected to follow up the continuing improvements made after concerns identified in previous inspections and to assess the provider's continuing compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at key questions of the safe, effective, caring, responsive and well led domains.

Summary of this inspection

We reviewed specific documentation and interviewed key members of staff including three sonographers, three healthcare assistants, and the senior management team who were responsible for leadership and oversight of the service. We also spoke with five patients who had recently used 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 a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The service should ensure that all ultrasound equipment units intended for continuing use in the service are included in current maintenance servicing contracts and that all equipment at locations is correctly identified in asset registers.
- The service should ensure that relevant national guidance for pause and check processes is reviewed and applied appropriately for the diagnostic and ultrasound procedures provided.
- The service should ensure that consent processes and documentation for transvaginal and other invasive scan procedures are reviewed to ensure a consistent approach.
- The service should consider developing a vision and strategy.
- The service should review the Freedom to Speak up process to ensure this remains impartial and protects anonymity of staff.
- The service should continue to embed and strengthen governance and risk management systems and processes to ensure there is continued effective oversight of clinical and operational activities at all service locations.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Diagnostic and screening services

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

Are Diagnostic and screening services safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

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

Staff received and kept up to date with their mandatory training, which included core subjects such as adult basic life support skills, consent, infection prevention and control, and health and safety. In addition to mandatory training, clinical staff had completed further training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. There was a continuing focus on maintenance of current and relevant training for all staff, with evidence of further training completed by staff in non-mandatory subjects, including for example, stroke awareness, arthritis care, and awareness of visual impairments in older people. The service was looking to access further equal opportunities training courses from an external provider.

The mandatory training was comprehensive and met the needs of patients and staff. Records confirmed all mandatory training was 100% completed by all staff.

Managers monitored mandatory training and alerted staff when they needed to update their training; staff received email prompts when their mandatory training was due, and this was reviewed by managers in one to one meetings with staff.

Safeguarding

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

We saw at our last inspection in March 2022 that staff had completed relevant updated safeguarding training which included children and adults' safeguarding level three for clinical staff; and children and adults safeguarding levels one and two for non-clinical staff. Following completion this initial training, staff had continued to undertake regular desktop exercises and discuss scenarios to maintain their safeguarding knowledge and skills.

Good

Diagnostic and screening services

Since the last inspection, in addition two members of staff had completed further training to become designated safeguarding leads, as well as another two members of staff completing safeguarding adults and children level four training.

The safeguarding leads continued to have access to specialist safeguarding advice when needed through an external consultancy service who had been working with the provider since November 2021. This model of support was now moving towards a handover to local service staff, who had developed and gained skills and experience for leading the continued improvements to safeguarding. Staff were fully aware of safeguarding systems and processes in the service and confidently described the types of issues which could present as a safeguarding concern. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. At the time of inspection, the service was continuing to see only a small number of private patients; there had been no safeguarding concerns identified from these. In clinics at two London locations where patients were beginning to be seen, an arrangement had been made with the local clinical commissioning group for safeguarding supervision.

Cleanliness, infection control and hygiene

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

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

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff in the service continued to complete infection prevention and control (IPC) cleaning checklists for different parts of the service, undertaking spot checks as part of their ongoing process for managing infection prevention and control. This included environmental cleaning checks and equipment cleaning. Records we reviewed indicated environmental cleaning and equipment cleaning checks were fully completed and up to date at the satellite locations.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff followed local procedures at satellite clinics for environmental cleaning in addition to the service's routine checklists and had access to PPE in the different satellite locations.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. At the last inspection we found staff gave varied responses regarding the type of probe covers used for intimate diagnostic procedures and the cleaning regimes for this procedure. At this inspection we saw the provider had updated their processes to use probe covers which were prefilled with gel, reducing any risk of cross infection. Clinical bins were available for appropriate disposal of probe covers.

Environment and equipment

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

The design of the environment at the Ashton satellite location we inspected was appropriate for the ultrasound services offered. Premises were accessible, with a patient waiting area and toilet facilities, a reception area, a separate private clinic room which contained a treatment couch, ultrasound and related equipment, and a lockable storage area. Staff had access to supply of stock consumables, including PPE, at the satellite location.

Good

Diagnostic and screening services

Staff carried out safety checks of specialist equipment. We noted at the last inspection in March 2022 there were 18 portable and two static ultrasound machines which had not been identified in the provider's asset register or included in current service maintenance contracts. The registered manager told us some of this equipment had been sold since the last visit. At this inspection we noted that weekly and monthly quality assurance checks had been completed during April and May for the relevant ultrasound equipment held in stock. Quality assurance audits were identified in the providers audit schedule but had not yet been completed, due to the limited clinical service activity to date. The provider's contingency plan for equipment failure at locations stated there would be a second ultrasound machine kept on site in the event of any equipment failure. However, during our visit we could not identify this second machine, and there appeared some inconsistency with the machine asset register identifiers and the equipment at the location.

The service used the picture archiving and communication system (PACS) which had been implemented at the last inspection. The PACS lead had responsibility for all equipment issues in the service, with clear and embedded systems now being established.

Sonographer staff had appropriate training for use of the ultrasound equipment and all staff had completed appropriate basic life support skills training for use of emergency equipment.

Routine portable appliance testing was completed and up to date. First aid equipment was available on-site and included emergency resuscitation equipment accessible at GP surgeries. We reviewed the current fire safety certificate for the Ashton clinic during this inspection.

Assessing and responding to patient risk

Systems and processes had continued to improve for the appropriate and timely referral, triage and escalation of patient care. Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Managers completed an initial triage of referrals for accepting to the service, with any inappropriate referrals returned to the GP as required. The service had an exclusion criteria for referral which noted they would not accept patients for thyroid scanning; any oncology patients; or any patients requiring breast scans. The clinical lead completed a clinical triage of referrals for prioritisation, following the service's Policy for Justifying Medical Examination by Ultrasound policy.

At the time of inspection, the clinical lead was the main individual completing this triage, however, all sonographers in the service met together every month for a discrepancy meeting where any inconsistencies would be identified.

Staff shared key information to keep patients safe when handing over their care to others. Since the last inspection the service had reviewed its processes for following up private patients who had self- referred to the service to meet British Medical Ultrasound Society (BMUS) guidance. The service would contact the local GP by phone in the event of any untoward findings, and this would be added to a log of urgent referrals. Any untoward findings from routine NHS referred patients were followed up in contact with GPs. The service kept a log of any follow up contact with GPs that had been made further to any concerns identified from diagnostic procedures. Managers reviewed this information during weekly team meetings and monthly governance meetings.

However, we found in specific discussions with clinical staff there was no clear process for applying BMUS 'Pause and check' guidance and a general lack of awareness regarding the identifiers to use for this procedure. Pause and check is designed to be a ready reminder and prompt for the checks that need to be made when any ultrasound examination is undertaken.

Good

Diagnostic and screening services

Staffing

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

The service had been able to maintain its staffing level since the last inspection, whilst patient services were beginning to be resumed. The registered manager was the clinical lead in the service. Two locum sonographers who had been continuing to work in NHS services during 2021 were now starting to work in satellite locations where clinics were resuming. The service's permanent staff included four healthcare assistants, an operations manager, complaints manager, health and safety manager and a secretary. Additional expertise was also available from an external consultancy to support the continuing improvements.

There were clear staff induction processes for any new staff, and checklists of staff competencies were maintained for all staff, including those working on a flexible basis in the service.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Records were stored securely.

At the last inspection the service had updated their records management/health records policy, dated December 2021, which referenced national guidance relevant for the service. This included updated information about the PACS system and the process for image transfer. Records audits were included in the audit schedule however none had been completed since the last inspection in November 2021.

Patient records were electronic, including consent documentation. The consent form for transvaginal scans was due to be fully incorporated into the electronic patient record in April 2022, together with an update to the standard operating procedure for satellite clinics for this. We saw at this inspection a discrepancy in the process for recording consent for transvaginal scans. The consent form on the electronic patient record had a field for the patient to add their signature, however this was not able to be accessed by the patient for them to complete. The service did not retain any equivalent paper documenting patient consent for transvaginal scans. Administrative staff or the sonographer would complete the electronic field in this situation after discussion with the patient.

Investigation reports were completed following the service's reporting policy which stated " Mediscan will ensure that the Diagnostic Report is produced according to the guidance as set out within the document 'Standards for the Reporting and Interpretation of Imaging Investigations' as published by the Royal College of Radiologists and as updated from time to time in the form agreed with the Commissioners and GPs.

The Report will provide the Referrer with a differential diagnosis wherever possible, and this will be based upon the presenting complaint as given in the referral and the objective findings of the scan.

The usual format will include:

- Clinical details (unless the request form details are readily accessible for review)

- A description of the findings

• A conclusion or interpretation of the findings in the clinical context."

Report documentation we reviewed at inspection demonstrated this process was followed.

Staff continued to complete general administrative checks of scans, following a prescribed checklist. The service also held a monthly clinical discrepancy meeting as a desktop exercise to review scan accuracy and quality. At the time of inspection there were limited results of this available due to the lack of clinical activity.

Incidents

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

Staff knew what incidents to report and how to report them. Since the last inspection all staff had continued to embed new systems in the service for reporting complaints, incidents and significant events. Staff were fully aware of how to report any incidents in the service and shared any feedback further to an incident in weekly team meetings. The incident and complaints manager continued to lead developments in incident investigation and shared learning from this. Incident monitoring was also identified in the audit schedule.

The service had no serious incidents or never events.

Staff raised concerns and reported incidents and near misses in line with the service's policy. We saw the service had undertaken a full investigation of an incident which had occurred at the time of the last inspection in March 2022, completing their full investigation by following the newly identified systems and processes.

Staff, including those at satellite locations, were fully aware of the new processes for incident reporting and raised these through the service's incident and complaints form. The incident and complaints manager reviewed all reports of incidents or complaints, recording these separately in an incident log and/or a complaints log.

Staff met to discuss the feedback and look at improvements to patient care. Managers reviewed all incidents and complaints at weekly management meetings and monthly governance meetings.

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

Are Diagnostic and screening services effective?

Inspected but not rated

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

Good

Diagnostic and screening services

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Staff had access to current relevant policies and procedures via the service intranet system, with paper documents of key policies also available at the satellite location we inspected. We saw staff were able to access electronic policies and wider service information as needed at the satellite clinic.

There was a clear programme of work for ongoing review and update of service policies and procedures, to ensure these were aligned to the processes in the service. Since the last inspection, further standard operating procedures had been identified for specific activities in the service, with related audit processes to support these. Managers observed that the focus now was to consolidate the range of new policies that had been identified during 2021 into a more streamlined approach.

Nutrition and hydration

Staff gave patients food and drink when needed.

Staff made sure patients had enough to drink prior to diagnostic procedures as necessary. Water was provided at satellite locations for patients who needed this for specific scan procedures.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service provided care and treatment based on national guidance and evidence-based practice. Outcomes for patients were positive and met expectations. Systems were identified for managers and staff to use the results to improve patients' outcomes.

Managers and staff had identified a comprehensive programme of repeated audits to check improvement over time. The quarterly performance dashboard compliance report dated June 2022 showed all identified audits were 100% compliant. There was continued focus on making improvements to quality assurance processes, with initial results available from the service's audit schedule. Managers had a process for reviewing information from the audits to improve care and treatment.

Managers shared and made sure staff understood information from the audits. Staff discussed audit results at weekly team meetings and managers monitored audit outcomes to identify where performance could be improved.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. We reviewed staff files at the last inspection and saw these remained current at this inspection. There was evidence of appropriate checks, including registration documents-employment checks and application form, DBS, two employment references, GDPR consent form, and contract of employment in each folder. The service did not employ any agency staff at the time

of this inspection, however there were relevant contracts with two national staffing agencies through which all staff would have the appropriate recruitment checks prior to working in the service. The service anticipated that agency staff may be used in the future, depending on the establishment of new contracts and the development of service provision. There was a system for any new staff, including agency staff, to complete a full induction tailored to their role before they started work.

The induction policy described a two-stage induction process which applied to all clinical and non-clinical staff. The list was comprehensive for mandatory training requirements including, basic life support skills, infection prevention and control, safeguarding training mental capacity act, sepsis training. Stage one incorporated a general introduction to the service and team, with stage two based on learning and supervision completed over a four-week period. The registered manager completed sign off for the staff induction when the staff member was deemed competent

Managers supported staff to develop through yearly, constructive appraisals of their work. All staff had regular one to one meetings with their line managers as well as annual appraisals. Since the last inspection, all service leads had completed additional bespoke training, relevant to their role.

The registered manager supported sonographer and healthcare assistant staff to develop through regular, constructive clinical supervision of their work. We reviewed some of the service's completed sonographer peer review documents and saw these were current and up to date for all sonographer staff. Peer review documents also included specific details and suggestions for individual staff to improve. Some of these comments included direction for staff members to avoid use of generic descriptions and use correct anatomical terminology in reports.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff confirmed they continued to attend weekly team meetings and the service kept records of staff attendance at meetings. Staff received email minutes of meetings following their leave and we saw continuing regular communications in day to day practice across the service. All staff were kept informed and aware of the overall service activity in practice.

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

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff in the service were exploring possibilities of introducing national vocational qualifications for healthcare assistants.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Leads for different areas of the service worked together to offer appropriate and timely services for patients. The service had principal relationships with GPs as referrers of patients, and systems were in place for effective communications, and escalation of any concerns where these were identified. Staff working in host GP clinics described good day to day working relationships with other staff at these locations.

Seven-day services

Key services were available to support timely patient care.

Good

Diagnostic and screening services

The service mainly offered patient appointments Monday to Friday, during working hours. The service also had flexibility to arrange appointments at weekends where this was needed.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. We observed different information was displayed in clinical areas for this, including NHS leaflets and information about how to seek support for managing chronic health conditions.

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.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care and explained procedures that the patient was receiving.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records.

At previous inspections we noted the service was due to update their consent form for transvaginal scans in April 2022. We saw the form contained a field for the patient to sign. However, since it was a digital form, there was no mechanism for the patient to be able to do this and the service did not keep paper records of consent. There was inconsistency with the service's consent policy in this process. At the time of patient appointment, the sonographer documented the patient's consent for the procedure. The providers consent policy identified that monthly consent audits would be completed. At the time of inspection these had not yet been able to progress due to limited clinical activity in the service.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and they knew who to contact for advice.

Are Diagnostic and screening services caring?

Good

Compassionate care

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

During the inspection we spoke with five patients who had recently had ultrasound scans in the service. Patients told us staff were discreet and responsive when providing care. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness and they felt staff respected their privacy and dignity.

Good

Diagnostic and screening services

Staff were aware of patient confidentiality and followed the service's policies to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. and understood patients' personal needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff were sensitive to patients' individual circumstances and took time to explain procedures and what would happen next. Patients said they felt informed about what to expect during and after the scan.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Some patients we spoke with were not clear about exact procedures that had happened for gaining their consent prior to their appointment, but all said that staff had explained what the procedure would be at the time of their scan.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients gave positive feedback about the service.

Are Diagnostic and screening services responsive?

Good

Our rating of responsive stayed the same. 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. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. Following the period of suspension during 2021, ultrasound services were being offered on a limited scale of provision, principally at clinics in Manchester and London. The service was in discussion with local clinical commissioning groups in different regions regarding possible future expansion of services and new contracts. The service had continued to offer private scans at the local clinic, with only 20 patients having been seen since January 2022.

Good

Diagnostic and screening services

The service minimised the number of times patients needed to attend, by ensuring patients had access to the required staff and tests on one occasion. Reporting times for urgent scans could be progressed within 24 hours.

Facilities and premises were appropriate for the services being delivered.

The service had systems to help care for patients in need of additional support or specialist intervention.

Managers monitored and took action to minimise missed appointments.

Managers ensured that patients who did not attend appointments were contacted.

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. They coordinated care with other services and providers.

Staff had received update training to assist in identifying the needs of patients living with learning disabilities and dementia. Staff ensured that patients who required support from a carer received the necessary information to meet all their needs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. A hearing loop was available at the Ashton clinic and premises were accessible for patients.

The service had some information leaflets available although these were not all in languages spoken by the patients and local community. Chaperones were available in the service with information clearly displayed for patients about requesting a chaperone where preferred.

Managers made sure staff, patients, and carers could get help from interpreters or signers when needed.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times for treatment were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

Managers had implemented a direct booking system for referrals from GPs. Any inappropriate referrals would be identified in the triage process and returned to the referring GP if not accepted by the service. There had only been one occasion of a returned referral since the introduction of the direct booking system.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Staff in the service followed their Care Pathway Protocols policy which identified a flow chart for referral. The flow chart indicated that referrals would be reviewed and prioritised within 24-48 hours after being received. Once the referral was accepted, staff would make contact with the patient by phone and text

message. After three failed contacts the service would send a letter to the patient requesting their contact. If no further contact was received, the service would return the referral to the GP for further action. Following initial appointment, if a patient did not attend on a further two occasions, they would be referred back to their GP. Managers reviewed the numbers of any patients where they had been returned to the referring GP.

Managers worked to keep the number of cancelled appointments to a minimum and had systems to confirm patient attendance.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible.

Learning from complaints and concerns

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

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

The service clearly displayed information about how to raise a concern in patient areas. The provider's website gave details of how to contact the service in case of any complaint or concern.

Staff understood the policy on complaints and knew how to handle them. The service had completed desktop exercises in reviewing complaints and discussing scenarios; there had been a focus on upskilling staff in responding to complaints. Staff were confident in the complaints process and gave examples of some possible issues and how they would respond to these.

Managers investigated complaints and identified themes. There had been no new complaints since services had resumed and only an isolated concern regarding delay in accessing an appointment. The service had followed their processes in responding to two historic complaints regarding audiology services.

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

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints and concerns were reviewed and discussed at weekly management meetings and monthly board meetings. There was limited evidence of completed complaints investigations and lessons learnt due to the limited clinical activities in the service at the time of our inspection.

Are Diagnostic and screening services well-led?

Requires Improvement

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

Good

Diagnostic and screening services

Leadership

Leaders mostly had the skills and abilities to run the service although there was continuing support from an external agency to sustain improvements. Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The registered manager who was the clinical lead and a consultant radiologist in the service was currently engaged in NHS locum work on an intermittent basis. However, they were regularly present in the service not less than three days a week. The registered manager worked closely with the compliance and quality manager, and other members of the team. They were actively involved in the ongoing negotiations regarding wider service developments and contract activities.

The compliance and quality manager was continuing to be employed by the service through contractual arrangements with an external agency, which had specialist experience in regulatory compliance and the Health and Social Care Act 2008. The compliance and quality manager reported directly to the CEO for the service and was currently working directly in the service one day a week in this role, also being available flexibly outside of these hours during the week. At the time of inspection, this contract was continuing until December 2022. There were ongoing negotiations with the external agency for their continuing long-term future engagement. Plans had also been progressed for existing Mediscan staff to develop into leadership roles for the future.

Safeguarding leadership had now been established within the service, with ongoing development for identified staff to take over the leadership responsibilities for infection prevention and control. There was continuing access to external expertise, guidance and advice for infection prevention and control to support the existing processes which were now being established. The provider had continuing relationship with an external company for ongoing human resources management and related areas regarding employment.

The service had implemented clear procedures for resuming contracted services, in readiness for new commissioning agreements. They followed their mobilisation plan for community-based ultrasound services at satellite locations, incorporating key areas such as legal aspects; premises and equipment; information management and technology risk assessments and checklists. The model for staffing satellite clinics had one sonographer and a healthcare assistant providing services at locations, with a local area business development manager for management oversight and support to the teams at local and regional satellite clinics.

Following the improvements to systems, processes, and documentation, we saw all relevant HR records for staff, board members and directors remained appropriate and met the requirements of fit and proper persons regulations.

Vision and Strategy

The service had a broad vision for what it wanted to achieve but did not identify a detailed strategy or actions for how this would be achieved. The vision was focused on sustainability of patient centred services.

The service did not have a documented strategy; however, we observed a team meeting where there was a shared discussion about the service's vision. Staff were broadly aware of the service's intention to be focused on patient safety, best patient care and experience. The service had a central aim to meet patients' needs at a local level, with an intention to offer appointments within a six-mile radius for patients to have access.

Good

Diagnostic and screening services

Leaders in the service were aware of local and national priorities in diagnostic screening services and were realistic and ambitious in their continuing effort to be able to take on new contracts under NHS England's increasing capacity framework. At the time of inspection there were contract discussions with six local commissioning service areas.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

During the inspection, staff we spoke with said they felt respected supported and valued. They continued to focus on the improvement action plan and were proud of the work that had been achieved since the last inspection. Staff had a positive outlook and were happy that services were beginning to be delivered for patients again. Some members of staff particularly felt there was a clearer team-based approach in the service now, with staff more confident to share their views and raise challenge where this was needed. Staff observed there was an improved culture of openness and honesty in the service which had supported the overall improvements that had been progressed. There were opportunities available for staff to develop.

There continued to be some lack of clarity around the Freedom to Speak Up process and how whistleblowing concerns would be independently followed up, once the external agency would no longer be involved in supporting the service. However, staff were aware of the processes to follow should they have any whistleblowing or freedom to speak up concerns to raise.

Governance

Leaders operated governance processes, throughout the service and with partner organisations although these were yet to be fully tested. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service continued to embed the new governance structure and we saw that governance systems and processes had continued to become established since the last inspection. There were effective structures, processes and systems of accountability to support delivery of good quality services. However, governance systems and processes had not yet been fully tested due to the limited clinical activities at the time of inspection.

The service was continuing to meet with and report performance to local clinical commissioning groups. Service leaders attended monthly quality and performance review meetings for oversight of key performance indicators in ongoing service contracts. Managers told us they had received positive feedback from a recent contract quality review meeting.

Staff at all levels were clear about their roles and responsibilities. We reviewed meeting minutes for the monthly board meeting and governance meeting as well as weekly management meetings and the monthly meeting for the whole staff team. Service leads provided reports for their areas of responsibility, with each of the scheduled meetings following a standardised approach. The weekly management meeting agenda items included departmental updates; business development and operational delivery; and CQC updates. The monthly governance meeting agenda items included policies and procedures, audits and safety alerts; staffing; ICT, PACS, and equipment quality assurance. All the scheduled meetings included discussions about significant events and learning, including incidents, safeguarding and complaints.

Leaders could clearly articulate the reporting process for the effective flow of information from staff level to the board. Staff were clear about how they received information regarding service performance and any related issues. Staff could easily access key service policies and documentation via the service intranet and demonstrated their understanding and the effectiveness of the systems that had been embedded.

The service had implemented its audit schedule based on key policies. We requested details of the latest audit outcomes following the inspection. The quarterly performance dashboard compliance report dated June 2022 showed all identified audits were 100% compliant. At the time of the inspection we saw all policies that we reviewed were in date, relevant for their content, and clearly accessible. Since the last inspection the service had identified a private patient's policy which was appropriate for the services provided. The satellite clinic standard operating procedure had also been updated to identify clear responsibilities for sonographer and healthcare assistants working at locations.

Management of risk, issues and performance

Leaders and teams used systems to manage performance although these were not yet fully embedded. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Since the last inspection the service had continued to develop assurance systems and escalation processes to manage risks, issues and performance in the service. The service focused on the quality improvement action plan as their working document for identifying and managing risks in the service. The quality improvement action plan was still intended to be a dashboard report for the future, described as being a 'live' document for the continuing monitoring and management of risks in the service. However, at the time of inspection it remained mainly in the form of an operational service action plan. Rag - rated indicators on the action plan identified where there was any concern or delay to progress, however the service did not have an overarching risk register which directly related to any areas of concern that were identified. Governance and risk management systems had not yet been fully established or tested due to the limited clinical activities at the time of inspection.

During the inspection, the registered manager told us the main risk to the service was the sustainability and continuity of services for the future; however, we did not see this clearly identified as an organisational risk or in any risk register. Also, the service had not specifically identified the impact of staffing levels to meet the needs of the service during periods of fluctuating activity, nor outlined any future mitigations for this. However, we saw there were systems identified to monitor and escalate concerns in the service, although the service had not fully implemented a risk register

From the improvement action plan, we saw that key areas of work had been completed in some of the following areas: identifying care pathways for private patients; updates to COSHH files and risk assessments; process for review of the number of repeat scans. All the actions identified as 'should do' actions in the last CQC report were referenced and areas of work that were identified in previous enforcement actions were also referenced for continuing compliance and improvement.

PACS support was available 24 hours a day and 7 days a week for any issues arising from IT failure.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Good

Diagnostic and screening services

The service was developing mechanisms for a digital patient feedback form. This would provide a live report of patient experience aimed at enhancing existing methods of patient feedback.

Engagement

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

The service held regular weekly staff meetings to share key information and any feedback. Staff routinely shared in discussions on a day to day basis and were involved in decisions about the service. The service received feedback from patients through patient satisfaction feedback forms and through their social media platforms. During inspection we reviewed 34 patient satisfaction forms; feedback was mostly positive with only minor concerns raised in two of the feedback forms. The service sent GP satisfaction feedback forms to identify any learning or improvements from these. At the time of inspection due to the limited scale of clinical activity, the service had not received any feedback to act on, this being mostly positive.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Staff were fully engaged in the quality improvement programme and were involved in identifying and leading further developments, based on the actions implemented.