InsideVue Ltd

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Farnham Centre for Health is an independent ultrasound service operated by InsideVue. The service registered with the CQC in 2012.

It was last inspected in 2013 under the previous CQC inspection methodology and met the standards that it was measured against.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 5 September 2018.

We rated the service as good overall.

Our key findings were as follows:

- Staff had undertaken mandatory training and training specific to their roles to support the delivery of safe care.
- Staff had the right qualifications, skills and knowledge to do their job.
- Staff understood the principle of assessing mental capacity and best interest decisions but they had not had to apply this knowledge.
- The service was planned and delivered in a way which met the needs of the patients. Patients had timely access to appointments of their choice and staff were flexible in their approach, which ensured patients' needs were met.
- Staff were aware of their responsibilities within adult and children safeguarding practices and support was available within the hospital for them to protect people in vulnerable circumstances.
- Information on how to raise a concern or complaint was available. Complaints and concerns were responded to in line with the complaints policy.
- Staff were aware of their responsibilities to report incidents and there was a good incident reporting culture amongst staff.
- There was a comprehensive appraisal process where clinical staff were supervised by the clinical lead radiologist.
- The service had a clear vision and strategy that staff knew about.
- The views of staff, patients and stakeholders were gathered and action plans developed to improve the service.

However, there were areas where the service needs to make improvements.

The service should:

- Conduct regular monitoring of hand hygiene, and take action when risks are identified.
- Ensure ultrasound scanners are serviced at regular intervals in line with manufacturers guidelines.
- The service should formalise and minute staff meetings.

Dr Nigel Acheson
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good	Overall, the care provided by the service was safe, effective, caring, responsive and well led. Patients were happy with the care they received and found the staff to be caring and compassionate. Staff were well trained and supported and worked according to agreed national guidance to ensure patients received the most appropriate care. There were sufficient staff, with appropriate skills and expertise to manage the service. Patients told us staff were professional, friendly and provided an excellent service. The number of compliments far exceeded the complaints. Over 99% of scans were reported and sent to the referring GP within 24 hours of the scan being completed.

Summary of findings

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Good

Farnham Centre for Health

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Summary of this inspection

Background to InsideVue Ltd

InsideVue Limited provides an independent ultrasound service at Farnham Centre for Health. The service opened in 2007 and is located within Farnham Hospital and primarily serves the communities of Farnham and the surrounding areas. InsideVue Limited provides a range of ultrasound examinations to both children and adults which include but not limited to abdominal, transvaginal, musculoskeletal and vascular. The service shares facilities with River Wey Medical Practice which include a waiting room and has two ultrasound scanning rooms. One of the two ultrasound rooms is dedicated to InsideVue Limited and the other is shared with a neighbouring practice within Farnham Centre for Health.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector and a specialist advisor with expertise in diagnostic imaging. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Information about InsideVue Ltd

The service provides diagnostic imaging and is registered to provide the following regulated activities:

- Diagnostic and screening procedures.

During the inspection, we visited two ultrasound scanning rooms and their associated clinical areas. We spoke with six staff including; the service manager, the infection control lead, administrative staff, sonographers and a director of the service. We spoke with two patients and one relative. We also reviewed patient satisfaction surveys. During our inspection, we reviewed four sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected once, and the most recent inspection took place in February 2013, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (September 2017 to August 2018)

The service undertook 8,900 scans during the year. All patients were NHS-funded.

Track record on safety

- No Never events, serious injuries or deaths
- One serious clinical incident reported with no harm.
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff) or E-Coli
- Four complaints

Services provided at the service under service level agreement:

- Cleaning services
- Maintenance of medical equipment
- Clinical staffing provisions
- Data sharing provisions

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 outpatients and diagnostic imaging services safe?

Good

Mandatory training

- InsideVue Limited provided mandatory training in key skills and made sure all staff completed it. The operations manager was responsible for reviewing compliance and informed staff of when they were due an update. Staff reported that they knew how to access mandatory training and were supported to do so.
- At the time of our inspection 96% of staff had completed mandatory training, however this did not meet the service target of 100%. The operations manager was responsible for ensuring staff were up to date with training and booking their training. The operations manager informed staff via email when their mandatory training was due to expire. This ensured training was well managed and the majority of staff had received training essential to providing safe patient care.
- Mandatory training courses were delivered as part of refresher training and development and included 'face to face' and 'e-learning' modules. Staff training files included a contemporaneous training record. This included details of training undertaken including; fire safety, health and safety, equality and diversity, infection control, moving and handling, safeguarding adults level one and two, safeguarding children level one and two, safeguarding level three, conflict resolution, basic life support and data security awareness.

Safeguarding

- There were systems, processes and practices to keep both adults and children safe from abuse. The safeguarding policy was in date and was due for review in December 2018. It described the definition of abuse and neglect, who might be at risk, general indicators and what actions to take if staff suspected abuse. The policies were in line with guidance and easily accessible on the service's shared drive and included contact details for safeguarding leads and designated nurses and doctors at clinical commissioning groups.
- Staff we spoke with had a sound understanding about safeguarding, knew what possible signs of abuse might be and where to access support if they had any concerns. They were confident about how to escalate concerns to the safeguarding leads.
- InsideVue Limited had identified leads for safeguarding staff could access. There were three safeguarding leads who were GPs for the GP practice the service shared the premises with. The safeguarding leads were all directors of InsideVue Limited and were level three safeguarding trained in line with national guidance.
- All staff including, clinical and administrative staff had completed level one and two in safeguarding adults and children. This met InsideVue Limited's target of 100%. One sonographer who specialised in paediatrics had completed level three training in safeguarding children. This was in line with the

Safeguarding children and young people: roles and competencies for health care staff Intercollegiate document. The document states that, all non-clinical and clinical staff who have any contact with children, young people and or parents and carers require level two safeguarding children training. In addition to this, staff should be able to access a level three trained professional at any time during their work.

- The service had a female genital mutilation (FGM) policy which, was in line with the Department of Health female genital mutilation and safeguarding guidance for professionals (2016). We reviewed the policy and saw that it was in date. Staff were clear about how to escalate any concerns they had. FGM was not part of the mandatory training programme but three of the four sonographers had completed FGM training.

Cleanliness, infection control and hygiene

- The service had processes to control infection risk. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection, as detailed below.
- The waiting room and clinical areas of Farnham Centre for Health were visibly clean and tidy. General cleaning of the premises was undertaken daily by an externally employed cleaning contractor. Clinical staff were responsible for ensuring equipment was kept clean in-between patients and at the end of each clinic. There was a daily cleaning schedule which we observed had been completed daily.
- The ultrasound probe was cleaned before it was used on each patient. There were latex-free sheaths readily available to place over the probe if necessary. At the end of each procedure the clinician cleaned and prepared the couch for the next patient with clean paper. We observed the sonographer wash their hands and clean the probes.
- The service reported that 100% of both clinical and administrative staff had completed infection control training. There was an infection control policy which was shared with the GP practice. Staff knew where to find it. We reviewed the policy and saw that it was up to date and in line with the Department of Health (2009) The Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infectious and related guidance.
- The infection control lead for the GP practice and Farnham Centre for Health's operations manager conducted an infection control audit once a year. The last audit was undertaken in July 2018 and the service reported an overall compliance rate of 98%.
- The service did not continuously monitor compliance with the hand hygiene audit, so they were unable to ensure the spread of infection was minimised. An annual hand hygiene audit was carried out as part of the infection control audit to measure compliance with the World Health Organisation's (WHO) "5 Moments for Hand Hygiene". These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene to reduce risk of cross contamination between patients. The service performed well in their audit, and results from the July 2018 showed a compliance rate of 97%. Although compliance with the hand hygiene audit was good, we were not assured that this was the case all year round, as it was not regularly monitored. We fed this back to the operations manager who told us they planned to review this.
- Hand hygiene results were communicated to staff through email. The infection control lead recommended that staff followed the hand washing technique as per the service's infection control guidelines policy.
- We observed throughout our inspection that all staff were compliant with best practice regarding hand hygiene, and staff were bare below the elbow.
- Hand gel was available throughout the centre and in the scanning rooms. We observed staff using the hand gel before providing care and when moving from one area of the service to another.
- There was a Methicillin-resistant Staphylococcus aureus (MRSA) policy which explained the process of booking, scanning and cleaning the scanning room after the procedure. This was to ensure the risk of cross infection was reduced or removed. We reviewed the policy and saw that it was up to date.

- Domestic and clinical waste was handled and disposed of in a way that kept people safe. Staff used the correct system to handle and sort different types of waste and these were correctly labelled. A waste management audit was conducted as part of the annual infection control audit. Results showed 100% compliance.
- Personal protective equipment including latex free gloves were readily available in all clinical areas and we observed staff using it.

Environment and equipment

- The maintenance and use of equipment generally kept people safe. However, during our inspection we noted that one of the ultrasound scanners was last serviced in August 2017. The service had continued to use the scanner. The operations manager said they were in the process of arranging a service date with the manufacturer and we were shown emails to prove this.
- Ultrasound equipment had a yearly service carried out by manufacturers' engineers. Alongside this, quality assurance checks were conducted every three months by one of the sonographers. We reviewed the last quality assurance check which was completed in June 2018. Results of the checks, including any new issues identified were recorded, with instructions either to monitor or to take immediate action to resolve the issue. An additional note to monitor the machine for further changes had been recorded in the actions required section. All other tests were normal with no actions required.
- There were clear processes for managing faulty equipment. Staff recorded faults in a log book and reported them to the operations manager. Staff told us the manufacturer was very responsive and we saw that faults were resolved within 24 hours of reporting the fault which minimised delays.
- Servicing and maintenance of premises and equipment was carried out using a planned preventative maintenance programme. We were shown maintenance and servicing records for ultrasound equipment.
- The layout of the unit was compatible with health and building notification (HBN06) guidance which gives guidance for the design of diagnostic imaging facilities. Clinical areas were easy to access, car parking was free with a secure entry point to the unit. The service shared a reception area with the GP practice and magazines and toilet facilities were available for patients and relatives.
- The service had two ultrasound scanners, each in its own clinic room. The scanning rooms were spacious and had good lighting which when dimmed allowed ultrasound scans to be clearly seen.
- We saw well stocked clinic store cupboards with equipment needed for ultrasound such as gels and transducer sheath covers. Staff had access to all the equipment and supplies they needed to provide a good service. Part of the daily cleaning schedule included stock take, so staff were always aware of what supplies were available and when to order more.
- Generator testing was completed every month on a planned schedule. This was to ensure that in the event of a power cut, the service could scan patients with minimal disruption.
- The service had access to the GP practice's emergency equipment which included a defibrillator. The equipment was visibly clean. Single-use items were sealed and in date and the defibrillator had been serviced in the last 12 months. Records indicated emergency equipment had been checked daily by nursing staff for the GP practice and ready for use in an emergency.
- Fire safety training formed part of the mandatory training programme. Mandatory training records showed 93% of staff were complaint with training. Fire alarms were tested every Thursday morning. We observed fire notices indicating the nearest exit and the assembly point. We checked four fire extinguishers and found they were in date and due for service in April 2019.

Assessing and responding to patient risk

- The service considered and took actions to lessen risks to patients.
- Patient referrals were screened against a criterion set by the clinicians to risk assess patients and ensure the service could respond to those risks. GPs were given the criteria to follow when requesting a patient to be

scanned, however, the administrative staff screened all referrals before accepting. Patients suspected to have a malignancy, those who weighed over 140kgs and those requiring hoisting were referred to secondary care with the necessary equipment or patient pathways.

- The service had a robust process for reporting any unexpected findings such as suspected cancer from ultrasound scans. Results of this nature were immediately sent to the referring GP. One sonographer said they contacted the GP via telephone to discuss findings and make suggestions of actions to take including further and alternative diagnostic tests. This ensured that unexpected findings were promptly and properly investigated. We spoke to one GP who confirmed this and said they arranged the correct treatment in a timely manner.
- Basic life support was included as part of mandatory training programme. The service reported that 100% of clinical and non-clinical staff had completed the training. Staff we spoke with were able to describe the process involved when managing a deteriorating patient and the situations which required immediate transfer to hospital such as a cardiac arrest, sudden collapse and deep vein thrombosis. The service had immediate access to medical staff at River Wey Medical Practice. Staff were able to contact the duty doctor who then advised whether transfer or admission to an acute hospital was required. The service reported one incident when a patient was transferred to A&E after an unexpected deep vein thrombosis finding.
- The service had reported no incidents of wrong site or side scans. There was a process to ensure the correct person and the right anatomy was scanned each time to minimise and prevent mistakes. We saw the Society of Radiographers (SoR) “Pause and Check” posters in the scanning rooms. These were a visual reminder which staff followed before starting the procedure. Pause and Check consists of the three-point checks to correctly identify the patient, as well as checking with the patient the site/side to be imaged.

Staffing

- The service had enough staff with the right qualifications, skills, training to provide the right care and treatment.
- The service had four sonographers who were self-employed. Clinical staff worked on a part time basis to fulfil the service’s requirement. Each sonographer worked specific days that they had formally agreed with InsideVue Limited however, they decided on the specific working hours. Staff were flexible with their working hours, so extended their day if required.
- All sonographers working for the service were registered with the HCPC and met the standards to ensure delivery of safe and effective services to patients. The operations manager was responsible for checking that staff were registered with the professional body and kept evidence of this.
- The service employed three full time and one part-time administrative staff members.
- There were no current sonographer or administrative vacancies and the service did not use bank or agency staff. Data provided to us prior to the inspection demonstrated that in the three months before the inspection, there were no episodes of sickness amongst both staff groups.

Medical staffing

- The service had a clinical lead radiologist who was the registered manager. The registered manager worked part-time to a fulfil 0.1 full time equivalent post. Staff told us the clinical lead radiologist was easy to contact when not on site by telephone or email during working hours.
- The directors of the service were registered GPs although they did not have any direct contact with the patients routinely. They were available for medical advice if immediate action was required.
- There were no other doctors employed by the service.

Records

- Peoples individual care records were completed and managed in a way that kept people safe.

Good

Diagnostic imaging

- The diagnostic reports were produced in accordance with the Standards for Reporting and Interpretation of Imaging Investigation 2018 published by the Royal College of Radiologists. We reviewed four sets of electronic notes and found that records were accurate, complete, legible and up to date. Each report included; patient identification, date of the scan and of the report, clinical information, the name of the referrer and sonographer, as well as a description of findings.
- All patients who used the service were referred from one of the 25 GP practices within the local clinical commissioning groups. Referrals were received via a secure NHS email portal. Patients who had previously attended the service had their details checked to ensure they were up to date. Referral forms were attached to the patients' electronic record and a copy was printed and filed into the relevant clinician's clinic list. All paper referrals were kept securely in a locked cupboard for six months in case of any queries. Thereafter they were shredded on site by an external shredding company as per service level agreement.
- Images and reports were stored on an image exchange portal and were available at all times to other NHS provides. This was in line with the data sharing agreement, which set out to ensure continuity of care and to meet specific NHS requirements that diagnostic images and reports should follow the patient to their chosen place of care where appropriate.
- Patient images were stored on the ultrasound machine. Images were backed up to a hard disk which was stored in a locked safe in the manager's office. The operations manager and three of the service directors had access to the safe.
- Patient records were accessible to staff who were authorised to access confidential data. The operations manager was responsible for granting access. All new users were required to sign a confidential agreement as part of their contract before gaining access to patient data.

Medicines

- InsideVue Limited did not use any controlled drugs or medicines.

Incidents

- Staff reported incidents using an electronic incident reporting system. All staff had access to this and staff we spoke with said they knew how to complete the form. Staff were encouraged to report incidents, however the operations manager acknowledged that near misses were not always reported, so more work was required in that area.
- Patient safety was promoted through the sharing of incidents. Incidents were shared via email to ensure each person received the notification due to staff having different work days. Staff confirmed that they received notices of incidents by email and this was the most effective way of sharing significant events within the service.
- From August 2017 to August 2018 the service reported no never events and one serious incident. The incident related to an ultrasound report which stated that nothing was found on a scan. However, a lesion was detected on a computerised tomography (CT). A consultant radiologist felt that this might have been detected earlier on the ultrasound scan with further sweeps of the probe across the area of concern.
- Incidents were shared for learning purposes. Staff were aware of this incident and said this had been shared by the operations manager. We reviewed an email sent to staff describing the event. Staff were advised to be vigilant and advised to adopt a new scanning technique for best practice.

Are outpatients and diagnostic imaging services effective?

Evidence-based care and treatment

- Staff had access to policies and procedures and other evidence-based guidance via the service's shared drive. Staff we spoke with were aware of National Institute for Health and Care Excellence (NICE) and other guidance that affected their practice.
- The service had written locally agreed examination protocols in line with best practice guidance such as the Society and College of Radiographers and British

Medical Ultrasound Society (2017). We observed staff were adhering to local policies and procedures. Staff knew how the policies and procedures affected patient care.

Nutrition and hydration

- There was a drinking water dispenser in the waiting room accessible to patients and visitors. The community hospital had an on-site catering facility next to the service and this was available to all patients and visitors.
- To improve the quality of the image, patients having a renal scan were asked to drink one litre of water up to an hour and 20 minutes before the scan.
- For certain types of scans, such as abdominal scans, patients were required to fast for four hours before their examination to enable clearer imaging. Advice to fast and avoid drinks such as, milk, carbonated drinks and alcohol prior to the examination was included as part of the information patients received on their clinic letter.

Patient outcomes

- The service monitored patient outcomes through the patient satisfaction survey, waiting times, activity and "did not attend" audits. Secondary uses service data was also collected, audited and reported to the clinical commissioning groups every month to monitor performance. Secondary uses data is a comprehensive store for healthcare data enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.
- Clinical audits were carried out twice a year by the clinical lead radiologist. The quality of images and written reports were audited. The report was compiled with anonymised patient data and graded as 1) agree with findings, 2) minor discrepancy and 3) major discrepancy. Results of the audit report were shared with all clinicians. Audit results from February 2017 showed 168 scans were reviewed. There were zero serious discrepancies found in the audit and minor discrepancies were found in only 5% of the cases. The audit detailed what the discrepancy was and this was shared with all staff. Staff involved in audits were aware of the audit cycle and the need for re-audit to ensure imaging and reporting standards were maintained.

Competent staff

- Staff had the right qualifications, skills, knowledge and experience to do their jobs. Employment and qualification checks were carried out on all staff and copies were kept in a folder in the operations manager's office. Skills were assessed as part of the recruitment process. The clinical lead radiologist assessed all new clinical staff before they began working for the service.
- There was an induction programme for all new staff which was specific to their role. Records showed that all staff had completed the induction. The induction included an orientation of the service and the completion of competency assessments for clinical staff. Clinical staff were initially supervised by an experienced clinician before being signed off as competent to run a clinic independently. The period of supervision depended on the clinician's experience and support required.
- The clinical lead radiologist observed the scanning and the writing of reports. Furthermore, clinical staff underwent the same assessment process every year as part of their yearly appraisal.
- The operations manager was responsible for appraising administrative staff. The operations manager was appraised by the directors and the directors and clinical lead radiologist were appraised by independent peers.
- The service reported that 100% of staff had received an appraisal in the last year and this met the target of 100%.
- Sonographers do not have a protected title and are therefore not required to be registered with the Health and Care Professions Council (HCPC). All sonographers were qualified radiographers and radiographers that have an extended scope in sonography are required to be registered with the HCPC. Clinical staff were required to complete continuous practice development (CPD) to meet their professional body

requirements. Staff were required to renew their membership every two years and we saw that all clinical staff had successfully renewed their membership in March 2018.

- We saw certificates showing that all sonographers had post-graduate qualifications in ultrasound. Staff were encouraged and supported to undertake further training. One member of the clinical staff was doing a post graduate musculoskeletal course.

Multidisciplinary working

- Our observations and staff interviews revealed good multidisciplinary working with GPs, sonographers and administration staff. All staff said there was a culture of working together for the benefit of the patient. There was regular contact between all staff and we observed a member of the administrative staff seeking advice from the sonographer regarding a patients' pre-scan preparation.
- A referring GP spoke positively about the working relationship with InsideVue Limited staff. The GP described the service and staff as efficient and very responsive.

Seven-day services

- InsideVue Limited operated Monday to Friday between 8am and 5:30pm. Additional clinics were provided on a Saturday on an ad hoc basis to compensate for cancelled appointments or when the service experienced increased activity.

Consent and Mental Capacity Act (Deprivation of Liberty Safeguards only apply to patients receiving care in a hospital or a care home)

- Mental Capacity Act training was available for staff as part of the mandatory training. At the time of our inspection, 100% of clinical staff had completed the training. This meant that all staff had received training which equipped them to deal with MCA and DoLS issues.
- Capacity to consent information was requested on the referral form. If a patient lacked capacity, staff told us they followed Mental Capacity Act principles ensuring best interest decisions were made and least restrictive options were provided.
- Staff we spoke with were able explain their responsibility to gain consent from patients before carrying out any procedure and were aware of the procedure for assessing whether patients had capacity to consent to their treatment. We observed that verbal consent was obtained and recorded in patients' notes. Patients we spoke with confirmed they were asked if they wished to continue with the procedure.
- The service had reviewed and changed the process of gaining consent in response to an incident. Previously scans had been undertaken with explicit, written consent and InsideVue Limited's contract with the clinical commissioning groups stated that at minimum, explicit verbal consent was required. The service discussed with the commissioner and the safeguarding lead and they agreed to alter the contract to reflect this. The service still required explicit written consent for invasive or intimate examinations.

Are outpatients and diagnostic imaging services caring?

Good

Compassionate care

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Patients commented positively about the service and the staff. Patients commented that they were treated 'like a person not an object', staff were 'professional, friendly and helpful' and the service was 'excellent'. We saw staff treating patients respectfully and kindly and were friendly towards patients at the reception desk and over the telephone. We noted that the sonographers introduced themselves when they greeted patients to take them to the ultrasound room.
- The service carried out weekly satisfaction surveys based on the NHS Friends and Family Test. The questionnaire asked how likely they were to recommend the service to friends and family, how long they had to wait for an appointment after visiting

their GP and if they were provided with necessary information before their appointment. It also asked what was good about the care and what they could improve on.

- Each week one clinician was surveyed. All patients scanned by that clinician were given a survey to complete. Of the 105 patients who completed the survey in June 2018, 82% of patients stated they were extremely likely to recommend the service. The rest were likely to recommend.

Emotional support

- Staff supported people through their scans, ensuring they were well informed and knew what to expect.
- Staff provided emotional support to patients to minimise their distress. We observed administrative staff ringing each patient to provide them with details of their appointment. We saw comments from a patient saying, 'I normally feel extremely anxious however, the team made me feel calm'. Another patient said 'I was worried about the examination, but the radiographer was so very calm, kind and reassuring. The whole process was completed with dignity and respect'.
- Patients were offered a chaperone at the point of booking. We saw posters in the waiting room and scanning rooms advising patients of this service. Training records showed 71% of administration staff had completed chaperone training.

Understanding and involvement of patients and those close to them

- Staff took time to explain the procedure before and during the scan. Patients were given sufficient time to ask questions. Patients commented that they were informed of the findings and the follow up procedure or what action to take following the scan.
- The service allowed for a parent or family member or carer to remain with the patient for their scan if this was necessary.

Are outpatients and diagnostic imaging services responsive?

Good

Service delivery to meet the needs of local people

- The service planned and delivered services in a way that met the needs of patients. The importance of flexibility, choice and continuity of care was reflected in the service provided.
- Progress in delivering services against the contractual agreement was monitored monthly by the local clinical commissioning groups and through the measurement of quality outcomes including patient experience.
- The service occasionally provided Saturday or evening appointments to accommodate the needs of patients who were unable to attend during work hours.
- The service was located near established routes, with a bus stop a short distance away. Patients were also able to use free and accessible car parking. Comments from the patient satisfaction survey often mentioned the location of the service as being convenient and easily accessible.
- Signage directing patients to the service was clear, visible and easy to follow. We followed the signs from the main hospital reception to the service's reception area with ease.

Meeting people's individual needs

- Diabetic patients or patients with a nutritional condition that required them to eat at specific times had their appointments arranged to meet their needs.
- The service was accredited as dementia and learning disability friendly. The environment of the service was calm, with good lighting. There were disabled facilities allowing patients living with dementia to maintain their independence and dignity over their personal care.
- We saw there was access to a hearing loop fitted in the waiting area for patients with hearing difficulties.

- Wheel chair access to the service was managed well. There was sufficient designated space to manoeuvre and position a person using a wheelchair in a safe and sociable manner.

Access and flow

- People could access the service when they needed it. Waiting times from treatment were in line with good practice.
- The referring practitioner indicated whether the patient required an urgent or routine ultrasound scan on the referral letter. Administrative staff triaged patients accordingly using the clinically set criteria and would offer patients appointments at a date and time convenient to the patient. We noted comments from the patient survey stating that they had been giving appointments that suited them.
- New referrals were received via a secure NHS email address. The administrative team checked the emails throughout the day and any marked as urgent were immediately registered. Patients were then contacted and an appointment was booked. Patients suspected to have deep vein thrombosis (DVT) were offered a scan on the same day. If capacity had been reached, staff extended or added extra clinics so patients then accessed the service in a timely manner.
- Secondary user service data was collected, audited and reported each month to clinical commissioning groups. The service recorded the times taken between referral to them for a scan and a scan being booked. The target set by the clinical commissioning groups was within 10 working days of acceptance of referral and at an absolute maximum of 20 working days (four weeks). Data from July 2018, revealed that over 78% of scans were completed within 10 days of accepting the referral and 94% within 20 days. The ethos of the service was to be able to provide a responsive service and urgent appointments were usually available within 48 hours and non-urgent within seven to 10 days. We noted comments from the patient survey stating that they had been offered earlier appointments, but due to other commitments they were unable to take these.
- InsideVue Limited also recorded the time taken from the scan date to when the scan was reported and sent to the referrer. Reports from ultrasound scans were typed at the time of the scan which ensured that they were accurate and reduced the risk of backlog. In July 2018, 951 scans were recorded. We reviewed the records and saw that over 99% of reports were sent to the referring GP within 24 hours of the scan being completed. This was in line with the two-day time frame set in the contractual agreement with the local clinical commissioning groups.
- From August 2017 to August 2018, 80 planned procedures were cancelled and 70 appointments were delayed due to severe snow. The service responded by offering patients alternative appointments and adding additional clinics at the weekends to compensate.
- The operations manager said the number of scans performed each year had increased over the years. The service had completed 8,900 scans from 2017 to 2018 compared to 5,570 scans in the year 2015 to 2016.

Learning from complaints and concerns

- The service treated concerns and complaints seriously, investigated them and shared any learning with staff.
- The service had a complaints policy providing guidance to patients on how to make a complaint. The policy was available on the service's website and we saw leaflets and posters in the scanning rooms and waiting room, visible to patients and visitors of the service. Information was available about other organisations patients were able to contact if they were not satisfied with the way the service dealt with their concerns.
- The operations manager was responsible for overseeing the management of complaints at Farnham Centre for Health. The operations manager told us they aimed to settle complaints as they arose. Patients were supported to make complaints if they wished to. Staff said they encouraged patients to discuss any issues directly with staff, so staff could respond promptly.
- The service received four formal complaints between August 2017 to August 2018. We reviewed all four complaints and saw that the service had given the patients an initial response on the day the complaint was received. A full response was given within 10

working days for three of the complaints, which was in line with complaints policy. The fourth complaint received a full response after three months, due to the clinical lead radiologist offering the patient a second scan for reassurance. The decision to wait three months was agreed with the patient and the lead radiologist to see if there had been any notable changes.

- Complaints and outcomes were discussed and shared with all staff to share learning and improve the service.

Are outpatients and diagnostic imaging services well-led?

Good

Leadership

- Leaders of the service had the right skills and experience to run the service. Managerial leadership was provided by the directors and operations manager. The operations manager was responsible for the day to day running of the service. Staff knew the management arrangements and their roles and responsibilities.
- The operations manager had been in post for four years and had worked for InsideVue Limited for 14 years.
- All the staff we spoke with told us that the service directors and manager were visible and approachable. Staff said the service leaders were open and honest with staff and operated an open-door policy.

Vision and strategy

- InsideVue Limited had a vision for what it wanted to achieve. The vision was to provide a rapid, high quality diagnostic ultrasound service with responsive, individualised care within a safe environment. Staff had an understanding of the vision and strategy.
- The operations manager told us it was important to have the staff involved in the strategic working and planning of the service because they were an essential part of delivering an efficient service.

Culture

- The operations manager told us staff views on the service were valued and that they played a vital part in delivering responsive care to patients. There was a sense of ownership and pride in the service provided.
- Staff told us that InsideVue Limited was a good service to work for and they felt proud of the service they provided for patients.
- Staff also said the s listened to their concerns if they had any and thought they were credible enough to deal with them. For example, at the last clinical governance meeting staff expressed doubts as to whether an electronic system used for reporting and sending reports to the referring GPs, was suitable due to it running slowly. Staff discussed other suitable options and the action decided upon, was to monitor the system whilst trialling another option. At the time of our inspection the service had begun emailing the reports directly to the referring service, through a secure NHS email.

Governance

- The clinical lead radiologist had overall responsibility for clinical governance and quality monitoring in conjunction with the InsideVue Limited directors.
- InsideVue Limited monitored and reviewed service level agreements for various services including cleaning services, maintenance of medical equipment, clinical staffing provisions and data sharing provisions.
- The directors and operations manager met once a year for a formal minuted board meeting. The agenda included finance, information governance, ongoing contracts with local clinical commissioning groups and procurement of new equipment. We reviewed minutes from the last board meeting in January 2018. Minutes showed a review and an update of roles and responsibilities for the year to come as well as updates of regulations. For example, the board discussed the General Data Protection Regulation that came in to force in May 2018. They agreed that all policies were to be reviewed and updated in line with the new regulation.
- Clinical meetings between the clinical lead radiologist, sonographers, operations manager and directors were held yearly. The agenda included but was not limited

to audit results, complaints and significant events and service updates. The operations manager told us informal team meetings were held as issues arose as it was difficult to gather all staff. However, these meetings were not minuted, therefore there was no audit trail of the discussion which made it difficult to identify trends and measure progress at regular intervals.

- The service had an ongoing clinical governance report. This detailed clinical concerns reported to the service by referring GPs throughout the year, with a comprehensive review, outcome and actions taken. Two of the six concerns reported had been shared with clinical staff.

Managing risks, issues and performance

- The service had processes to identify, understand, monitor and address current and future risks. The operations manager was the risk actions owner of 15 of the 27 open risks including the top risk. Failure to retain key staff was identified as the top risk at the last review. Controls to mitigate this and support staff included appraisals, daily access to service leaders and the operations manager and succession planning.
- Risks were divided into 10 categories including, government policy and regulatory, financial and compliance and governance, quality and health and safety. All risks were graded according to their level of impact. We saw that there were controls for each risk and mitigating actions. We were told that risks were overseen by the service directors and were reviewed at the annual governance meeting. Minutes from the governance meeting in January 2018 showed that some risks were discussed such as, information governance. However, the agreed actions were not updated on the risk register. We reviewed the policies associated with the risks on the risk register and noted they had been reviewed in the last 12 months.
- The service had robust procedures for securely sharing data, approved by InsideVue Limited's Caldicott Guardian (a person responsible for protecting the confidentiality of patient's healthcare information and ensuring it was used for the right purposes). The service used technology which anonymised personally identifiable information and replacing data fields with one or more artificial identifiers. This was used for contact with the NHS using the NHS number and encrypted NHS mail service. Anonymisation was used for reporting data to the clinical commissioning groups. Secondary uses survey data we reviewed, had personally identifiable information removed, so that the patients who the data related to remained anonymous.

Information management

- Data security awareness training was part of the mandatory training programme. At the time of our inspection 93% of all staff had completed this which did not meet the target of 100%. However, all staff we spoke with had a sound understanding of their responsibilities to ensure confidential data was kept safe.
- Electronic patient records were accessed easily but were kept secure to prevent unauthorised access to data. We observed that staff kept computers locked when not in use. Data was stored electronically, which allowed the service to collate and audit information to improve the quality of care provided
- All staff demonstrated they could locate and access relevant and key records very easily and this enabled them to carry out their day to day roles.

Engagement

- The service engaged well with patients, staff and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- Staff felt actively engaged and their views were reflected in the planning of the service. We were told of an informal and not minuted meeting between with the service leaders and clinical staff. The group discussed the increasing volume of patients and the future of the service. Staff discussed how they planned to meet the increasing demand with some staff volunteering to work additional days including running a Saturday clinic.
- The service engaged with local clinical commissioning groups. The service and the clinical commissioning groups met once a year. At the last meeting, they had discussed and agreed to removing foetal viability

scans from their contract, as staff did not have the capacity to offer patient support and counselling if required. This meant the service worked in close partnership with CCGs to plan and manage services.

- Results of the weekly satisfaction surveys, as well as any complaints, were discussed between team members at the time and at formal meetings. Action was taken in response to this feedback to ensure the best service was provided.

Learning, continuous improvement and innovation

- In the reporting period, improvements had been made to increase scanning capacity to meet the demand of NHS referrals. The service had bought a second ultrasound scanner increased staffing, clinics and availability of appointments in an attempt to ensure they increased capacity and continued to offer the same standard of care to every patient. We were told this was an ongoing process to manage the increased number of referrals.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- Conduct regular monitoring of hand hygiene, and take action when risks are identified.
- Ensure ultrasound scanners are serviced at regular intervals in line with manufacturers guidelines.
- The service should formalise and minute staff meetings.