The Gynaecology Ultrasound Centre

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?	Requires improvement

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Summary of findings

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

The Gynaecology Ultrasound Centre is operated by The Gynaecology Ultrasound Centre Limited. Facilities include two clinical rooms for examinations and ultrasound scanning. There is a changing cubicle and a clinical storage area in each room.

The Gynaecology Ultrasound Centre is a standalone service and provides a private clinical and diagnostic service for women with concerns about their gynaecological health, including early pregnancy. It does not provide a service to NHS patients. The centre offers transvaginal and transabdominal scanning as well as two and three-dimensional scans where appropriate. Most women are referred by their consultant or GP. It provides gynaecological diagnostic services to women over 18 years of age and family planning.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 6 February 2020.

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

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

The main service provided by this hospital was diagnostic imaging.

Services we rate

Our rating of this service improved. We rated it as **Good** overall.

- The service had enough staff to care for patients and keep them safe. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service learnt lessons from incidents.
- Managers made sure staff were competent for their roles. Staff worked well together for the benefit of patients. Consent processes were followed, and patients were advised on how to prepare for scans.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them to understand their scans. They provided emotional support to patients where necessary.
- The service planned care to meet the needs of their patient population and took account of individual needs. People could access the service when they needed it.
- Leaders were approachable and visible. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and responsibilities.

However:

- Leaders did not operate embedded governance processes throughout the service. Staff did not have formal opportunities to discuss and learn from the performance of the service.
- There was limited information around the service for patients, for example, there was no information on how to complain.
- The service did not use systems to manage performance effectively. There was no risk register or a formalised risk management framework. There were no plans to cope with unexpected events.
- There was no policy regarding transferring a patient out of the service should they become unwell during a procedure.
- There was no information online or in person on gynaecological health promotion.

Summary of findings

- Although prophylactic antibiotics were prescribed, we found there were no audits/policies in place to ensure they were prescribed in line with best practice.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice. Details are at the end of the report.

Dr Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	**Diagnostic imaging was the only core service provided. We rated this service as good overall. We rated safe, caring and responsive as good and well-led as requires improvement. We do not rate effective in this core service.**

Summary of findings

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Good

The Gynaecology Ultrasound Centre

Services we looked at

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Summary of this inspection

Background to The Gynaecology Ultrasound Centre

The Gynaecology Ultrasound Centre is operated by The Gynaecology Ultrasound Centre Limited. The service opened in 2003 and registered with CQC in 2013. It is a standalone private service in Central London and accepts self-referrals as well as referrals from consultants and GP's.

The service is registered for diagnostic imaging and screening procedures and family planning.

The hospital has had a registered manager in post since it registered with CQC in February 2013. This person is also the nominated individual.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector and a specialist advisor with expertise in radiological services. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

Information about The Gynaecology Ultrasound Centre

The location was registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Family planning

We inspected the registered location in Harley Street, London. We spoke with eight staff including the nominated individual/registered manager and clinic manager. We also spoke with health care assistants, secretarial staff and medical staff.

We spoke with two patients and reviewed six records.

During the inspection, we visited the reception, both consulting rooms and the office area. We spoke with eight members of staff including health care assistants, reception staff, consultants and managers. We spoke with two patients. During our inspection, we reviewed six sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The service had been inspected once before, which took place in January 2019. Following the previous inspection, we rated the service as 'requires improvement'. At our previous inspection we found a breach of Regulation 13 HSCA (RA) Safeguarding service users from abuse and improper treatment and Regulation 17 HSCA (RA) good governance. At this inspection, we found that the service was no longer in breach of Regulation 13 HSCA (RA) but was still in contravention of Regulation 17 HSCA (RA) good governance.

Activity (January 2019 to December 2019)

- All activity within the service was privately funded and no NHS patients were treated.

The clinic manager, deputy clinic manager, secretaries and two healthcare assistants (HCAs) worked full time at the service. One HCA worked part time. The registered manager was also the nominated individual and worked part time. Eight consultants worked at the service under practising privileges. The service did not use any controlled drugs and therefore did not have an accountable officer for controlled drugs.

Track record on safety (between January 2019 and December 2019)

- Zero Never events

- Zero serious injuries

Summary of this inspection

- Zero incidents of healthcare acquired Meticillin-resistant Staphylococcus aureus (MRSA),

- Zero incidents of healthcare acquired Meticillin-sensitive staphylococcus aureus (MSSA)

- Zero incidents of healthcare acquired Clostridium difficile (C.diff)

- Zero incidents of healthcare acquired E. coli

- Three complaints

Services provided at the hospital under service level agreement:

- Clinical and non-clinical waste removal
- Laundry
- Maintenance of medical equipment
- Medical oxygen supply
- Information technology support

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated it as **Good** because:

- Staff understood how to protect patients from abuse. All staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Clinic staff kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff identified and quickly acted upon patients at risk of deterioration.
- 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.
- Staff kept detailed records of patients care and treatment. Records were clear, up to date, stored electronically and easily available to all staff providing care.
- The service knew how to manage patient safety incidents, but none had been reported in the 12 months prior to inspection.

However

- Although prophylactic antibiotics were prescribed, we found there were no audits/policies in place to ensure they were prescribed in line with best practice.
- There was no policy regarding transferring a patient out of the service should they become unwell during a procedure.

Are services effective?

We do not rate effective for this core service. We found that:

- Staff provided care and treatment based on national guidance and best practice.
- Staff checked to ensure patients were comfortable during scans and offered them a drink for the length of their stay.
- The service made sure staff were competent for their roles.
- Staff worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available six days a week to support timely patient care.
- Staff gave patients advice in relation to their procedure.

Summary of this inspection

- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions.

However:

- There was no information online or in person on gynaecological health promotion.

Are services caring?

Good

We rated it as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their scan results.

Are services responsive?

Good

We rated it as **Good** because:

- The service planned and provided care in a way that met the needs of the patient population.
- The service was inclusive and took account of patient individual needs and preferences. Staff made some reasonable adjustments to help patients access services.
- People could access the service when they needed it and received the right care promptly.

However:

- The service did not provide information to people on how to give feedback and raise concerns.

Are services well-led?

Requires improvement

We rated it as **Requires improvement** because:

- The service did not have a formal vision for what it wanted to achieve, or a formal strategy to turn it into action.
- Leaders did not operate an effective governance process throughout the service. Staff at all levels were clear about their roles and accountabilities but had no regular opportunities to formally discuss improvement plans.

Summary of this inspection

- Leaders and teams did not use systems to manage performance effectively. There was no risk register or formalised risk management framework.
- The system lacked a robust approach to quality improvement.
- Information systems were not always secure, and the service had incidents involving sending medical reports to the wrong email.

However:

- Leaders had the integrity, skills and abilities to run the service. They were visible and approachable in the service for patients and staff.
- Staff felt respected, supported and valued. They were focused on the needs of the patients receiving care. The service had an open culture where staff could raise concerns without fear.
- The service engaged with patients and staff but there were limited opportunities for them to plan and manage services.

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	Requires improvement	Good
Overall	Good	N/A	Good	Good	Requires improvement	Good

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are diagnostic imaging 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 but not everyone had completed it.

At the time of our last inspection we found that the service did not have a policy for mandatory training. At the time of this inspection the service did not have a policy for mandatory training but did keep track of which training each staff member had completed.

Mandatory training of the nursing and secretarial staff included: basic life support, safeguarding adults, safeguarding children, equality and diversity, control of substances hazardous to health (COSHH), health and safety, fire safety, dementia awareness, chaperone, manual handling, infection prevention and control and female genital mutilation (FGM). All nursing and secretarial staff were fully up-to-date with their training. Some training was due to go out of date. Where this was the case, staff had been booked on to the training course in advance.

We went through the training logs for all consultants that worked at the service and found that not all of them were up-to-date on their mandatory training. Consultant mandatory training was organised by the consultant's respective NHS trust and followed up by the service.

Safeguarding

Staff understood how to protect patients from abuse. All staff had training on how to recognise and report abuse and they knew how to apply it.

At the time of our last inspection we found inadequate systems for raising safeguarding concerns. We found that the provider had made significant improvements since our last inspection around safeguarding. At the time of the last inspection, the service did not have a dedicated safeguarding children policy or protocol in place. Since then, the service had produced and ratified a safeguarding children policy which was due to be reviewed in April 2022. We observed the policy and found that it gave adequate reference to the national intercollegiate guidance.

The safeguarding children policy did not include any reference to female genital mutilation (FGM) at our last inspection. This was rectified and the policy now included reference to FGM and links to useful documents. The policy gave reference to the mandatory reporting duty in the FGM Act 2003 (as amended by the Serious Crime Act 2015). The legislation requires regulated health and social care professionals in England and Wales to make a report to the police where there are reports or concerns about FGM having taken place.

The service had improved their Safeguarding Adults Policy. The improved policy gave reference to FGM, defined types of abuse and provided contact details for making safeguarding referrals to the local authority. Staff could describe what might constitute a vulnerable person, including those at risk of domestic violence and abuse. At the time of the last inspection we found that not all staff were able to describe FGM and the signs to be

aware of. Since then, all staff had received training in FGM and knew to discuss any concerns with the designated safeguarding lead. There had been no safeguarding concerns related to FGM.

The 'Safeguarding children and young people: roles and competences for health care staff intercollegiate document: Fourth edition: January 2019' set outs the minimum training requirements for staff training. It states that all non-clinical and clinical staff who have contact with children, young people and/or parents/carers should have level 2 safeguarding children training.

At the time of our last inspection, we found that the designated safeguarding lead had level two safeguarding training but was not aware that level 3 was required. Since then, the designated safeguarding lead and deputy had been trained to level 3 and ensured that all staff were trained to at least level 2. We saw records that confirmed that all consultants with practising privileges had current level 3 safeguarding adults and level 3 safeguarding children training as part of their employment within the NHS.

There were no safeguarding referrals or concerns raised in the 12 months prior to our inspection.

Cleanliness, infection control and hygiene

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

At the time of our last inspection, the service did not have a process or policy to effectively audit infection control measures. At the time of this inspection, we found that the service had introduced an infection control policy which summarised hand washing techniques and the five moments of hand hygiene. We saw that staff followed National Institute for Health and Care Excellence (NICE) QS61 statement 3 and washed their hands immediately before and after every episode of care with a patient.

An external company cleaned the whole building.

Hand washing sinks and antibacterial gel was available in the clinical areas. Soap, paper towels and sanitiser were available on the trolley next to the ultrasound machine. We always saw staff adhering to bare below the elbows (BBE) guidance. We saw staff use hand sanitiser appropriately and in line with the World Health Organisation (WHO) 'five moments for hand hygiene'. Staff followed infection control principles including the use of personal protective equipment (PPE) when performing intimate examinations.

We saw staff decontaminating equipment after use. They used an automated high-level cleaning machine to sterilise the probes after each use. This process took seven minutes for each probe. Each probe serial number was recorded on the patient's record to provide a tracking system in case of infection.

There had been no incidences of healthcare acquired infections at the service in the 12 months prior to inspection.

Environment and equipment

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

The premises were secure, and patients rang a buzzer to access the reception area. This area had adequate seating for patients and relatives whilst they waited to be seen for their scan. The environment was visibly clean and well maintained.

The consultation rooms included two couches – this is where the initial consultation would take place. The patient would then proceed to the scanning area which included a scanning couch. Staff had enough room for scans to be carried out safely. There was a screen to view images, attached to the ultrasound machine. The ultrasound machine's manufacturer maintained and serviced it annually. We reviewed the service record history for the equipment and found it all to have been repaired on time.

Due to the nature of the service they did not require a resuscitation trolley. However, the service had access to an appropriate amount of resuscitation equipment in the form of: an automated external defibrillator (AED), oxygen cylinder and anaphylaxis box, which contained epinephrine. All medicines were in date and stored correctly.

Clinical waste was disposed of correctly, in clinical waste bags and stored in a locked bin in the basement until collected by a specialist waste company, who collected waste on weekly basis. Staff disposed of sharps, such as

needles, safely. We saw two sharps bins, each in a clinical room and found that they were not overfilled, were signed and dated when brought into use and had a disposal date listed.

Portable appliance testing (PAT) was carried out and was in date. For reasons of aesthetics, staff didn't put stickers on the kit itself. Instead, staff kept all the stickers that showed testing dates within a paper-based log. Staff kept a log of which stickers corresponded to which equipment but on the day of our inspection they weren't aware of which stickers corresponded to which machines. There was a clear process for maintenance of equipment and a number the service could call if they had to report any faults.

The service undertook assessments and reviews of their activities under the Control of Substances Hazardous to health Regulations 2002 (COSHH).

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. There was minimal risk of patients deteriorating but staff knew what to do in any event.

A medical questionnaire was used to screen new patients and if there were any concerns, the provider would refuse treatment and give a full explanation as to why. This questionnaire would then be verified by the consultant during the consultation and the consultant would double check the patient name, date of birth and type of scan. This is how the service ensured that the right person got the right scan at the right time. This evidenced staff followed best practice and used the British Medical Ultrasound Society's (BMUS) 'pause and check' checklist.

The service checked all patients for allergies. If a patient had a latex allergy, the consultant would ensure they used a different type of glove during the examination. There were two types of gloves just in case a patient was allergic to latex.

Time slots were booked for longer sessions if a patient was anxious or if the procedure was more complex. If the patient required further tests, the service would ask if they were comfortable being referred. If so, the service would refer for further tests. The service had a pre-procedure checklist similar to a modified World Health Organisation (WHO) checklist. On it there were patient details along with time in, time out sections. All sections need to be signed by both the doctor and the HCA.

Staff told us what action they would take if a patient became unwell or distressed while waiting for, or during, an ultrasound scan. All clinical staff were basic life support (BLS) trained. In case of emergency, the patient would be transferred to the most appropriate neighbouring NHS hospital, using the standard 999 system. However, at the time of inspection, there was no formal written policy detailing this process.

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.

There were two full time healthcare assistants (HCAs) and one part time HCA. The role of the HCA was to support the consultant during each procedure and act as a chaperone. The service had a receptionist at the front desk to greet patients and there was always one HCA who sat in on the procedure.

The service did not use agency staff and rarely used bank staff. Clinics were planned around consultants' availability and did not cancel any appointments. All staff we spoke to felt the staffing levels were sufficient to cover the work required. There was a formal induction process for new staff, which we saw documented.

Records

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

The service was paperless and so kept all records online on a system specially tailored for an ultrasound service. There were prompts available on the system that signposted staff to ask specific questions or input data, such as allergies. Any patients attending the service would receive a report written by the consultant at the time of the appointment. This report would then be emailed to the patient within 24 hours of the appointment. The report would also be sent to the patients' referring GP/consultant.

Good

Diagnostic imaging

We checked six electronic records. Staff recorded information in a clear and correct way. This included the reason for the scan, the findings, conclusions and recommendations.

The service did not keep any paper records. Consent forms were scanned straight away onto the electronic system.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

At our previous inspection, we found local anaesthetic and resuscitation medicines stored out of their boxes on a shelf in an unlockable cupboard, alongside cleaning materials. This had since been rectified and on this inspection, we found that medicines were stored in a locked cupboard with a thermometer present to keep track of temperature.

At our last inspection we found there were no stock control checks carried out on medicines and staff could not confirm if any medicine was missing. We saw that daily checks were carried out both on medicine storage and the temperature. These checks were all fully complete and showed no issues. These checks were carried out by a healthcare assistant (HCA) who kept a note of all drugs that were used. If there were any concerns regarding refrigerated medicines, the HCA would inform the clinic manager who would escalate the concern to the necessary person. All medicines were provided by a neighbouring pharmacy who also disposed of out of date medicines.

We found that all previous concerns relating to medicines had been rectified by the service.

Prophylactic antibiotics were prescribed for certain interventions such as biopsies. There were no audits/ policies in place to ensure these were prescribed in line with best practice.

Incidents

The service rarely had patient safety incidents.

The service used a paper-based reporting system to monitor all incidents. These forms were available to staff in the administration room. The clinic manager was responsible for handling investigations into all incidents.

Between January and December 2019, there were six incidents reported. All these incidents related to IT issues, such as sending reports to invalid email addresses. All staff were aware of these incidents and had adopted new practices to mitigate the risks. This new practice involved email addresses being checked and verified by two members of staff instead of one. The clinic manager told us that they would investigate any incidents and share lessons learned with the team in informal meetings.

In the year prior to our inspection there were no never events reported by the service. Never events are serious patient safety incidents which should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

In accordance with the Serious Incident Framework, the service reported no serious incidents (SIs) in the 12 months prior to our inspection.

Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with were aware of the duty of candour. There had been no incidents when statutory duty of candour had to be used since the service opened.

Are diagnostic imaging services effective?

We do not rate effective for diagnostic imaging services.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff were knowledgeable about the best practice guidance they used in their everyday work, for example, from the National Institute for Health and Care Excellence (NICE). All staff had access to the policy folder which contained paper copies of all provider policies. All policies were in date and showed evidence of review.

The service had a clinical audit programme to check staff followed policies and guidance. We saw that NICE

guidelines were followed. For example, the miscarriage audit showed that NICE guideline [NG126] were followed in 59 of 60 cases. The endometrial thickness audit showed that endometrial thickness was appropriately measured in all cases.

Nutrition and hydration

Staff offered patients fluids for the duration of their stay.

The service had access to water and hot drink facilities. We saw staff offering this to patients upon checking in for their appointment.

Staff gave women information on drinking water before certain scans to ensure they attended with a full bladder which enabled the consultant to gain a better view of the womb. The service did not offer general anaesthesia, so patients did not have to fast before a procedure.

Pain relief

Staff assessed patients regularly to see if they were in pain and gave pain relief in a timely way.

Post intervention pain relief was prescribed by the registered consultant and recorded on the patients records.

Depending on the procedure itself, staff sometimes advised patients to take pain killers before the procedure. For example, for a coil insertion, patients were provided with local anaesthesia and told to take their own pain medication beforehand. Consultants used local anaesthetic where necessary and we observed them asking patients if they were in any pain during the procedure

Patient outcomes

Staff monitored the effectiveness of care and treatment.

At the time of our inspection the service had not engaged with the Private Healthcare Information Network (PHIN) in accordance with the Private Healthcare Market Investigation Order 2014 regulated by the Competition Markets Authority (CMA). PHIN is an independent, not-for profit organisation working with the private healthcare industry on behalf of patients formalised by the CMA. It aims to publish independent, trustworthy information to help patients make informed treatment decisions, and providers to improve standards. It was not unusual that the clinic had not engaged with PHIN due to the small size of the service.

Consultants maintained an open conversation with the referring consultant/GP and followed up outcomes to offer both support and to assess the accuracy of the diagnoses through a telephone call or email.

The service undertook consultant peer review audits. The consultants reviewed each other's work and determined whether they agreed with their ultrasound observations and report quality and on such findings as gender or anomalies. This was in line with the British Medical Ultrasound Society's (BMUs) guidance, which recommends peer review audits are completed using the ultrasound image and written report.

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 had the right skills, knowledge and experience to carry out their roles and meet the needs of patients. There were arrangements in place for supporting new staff at the service. We viewed induction records for staff, which included instruction on information governance, safeguarding and chaperoning. Staff that we spoke to were satisfied with the induction process and how it prepared them for their role.

The service provided us with information which showed that all staff had received an appraisal in the past year. All consultants were appraised in their NHS practice and had to provide evidence of the appraisal to the service.

We observed that all healthcare assistants (HCAs) were working within the remit of their job descriptions.

There was support available from the registered manager if staff were under-performing. The service provided examples of staff being retrained if required.

Multidisciplinary working

Good

Diagnostic imaging

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

There was no formal multi-disciplinary team (MDT) meeting at the service. However, the consultants at the service received direct feedback from their referrers and shared this information amongst themselves informally. On the day of inspection, we observed good team working between the clinicians, the healthcare assistants and administrative staff. Staff told us that there were positive working relationships between all individuals at the service.

The service maintained good working relationships with neighbouring independent health services and large NHS trusts. The service ensured where the patient had consented for their information to be shared, GPs received a copy of the ultrasound report electronically.

Seven-day services

Key services were available five days a week and sometimes on Saturdays.

The service was formally open Monday to Friday between 9am and 5pm. The service did take into consideration patients that needed late appointments, emergency appointments or Saturday appointments and were able to accommodate this.

There were late clinics every day apart from Friday. The service was frequently open until 8pm Monday to Thursday. Depending on patient need, the service opened between 9am and 5pm on a Saturday.

Health promotion

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

There were no patient information leaflets at the service. The service website provided reasons as to why an ultrasound might be necessary. The service informed us that the patient's referring doctor would provide the patient with all necessary information both before and after ultrasound.

We saw no information on gynaecological health promotion.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions. They followed national guidance to gain patients' consent. They were trained in Mental Capacity Act and Deprivation of Liberty Safeguards.

Each procedure had a specific consent form that the patient had to sign accordingly. This consent form was then scanned onto the patient record. All patient records we observed contained relevant consent forms. We saw processes to gain consent from all patients. Staff we spoke with were able to tell us about the process used for gaining consent from patients.

All clinical staff at the service received basic Mental Capacity Act (2005) training through the NHS trust. Nursing staff received the training in house. Staff were able to verbalise the process to take when they believed a patient did not have the capacity to consent. Staff informed us that they had never had an incident of a patient lacking capacity to consent.

Are diagnostic imaging services caring?

Good

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

Compassionate care

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

We spoke with two patients in total and reviewed four patient comment cards. Feedback stated, "Thank you for dealing with the diagnosis and after care so professionally". Another stated, "Everyone was lovely, thank you". We observed interactions between staff and patients before, during and after two procedures. The consultant introduced themselves before starting a patient's scan, explained their role and next steps. Staff took time to interact with patients and answer all their questions.

At our last inspection, the service had initiated an independent patient feedback survey tool. There were no results available at the time of our last inspection. At this inspection we found that 100% of patients would recommend the service to their friends and family.

Good

Diagnostic imaging

All conversations during and after an appointment took place in the private consultation room. Patients were greeted at the reception and taken through to the clinic room by staff.

The service had a chaperone policy and staff ensured a chaperone was always available to support patients, particularly during intimate procedures. A chaperone is a person who services as a witness for both patient and clinical staff as a safeguard for both parties during an examination or procedure. All staff received guidance on how to perform this role at their induction.

Emotional support

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

During our inspection, we observed two appointments. Throughout these appointments the sonographer described what they saw and explained findings in a way the patients could understand. Staff provided reassurance and support for nervous and anxious patients. They demonstrated a calm and reassuring attitude to alleviate any anxiety or nervousness patients experienced. Patients were given 30-minute appointments, although scans often took much less time than this, so as not to rush them.

There was a quiet room available if a patient required more support or time. Patients we spoke with during the inspection told us they felt reassured by the information they were given before their appointment and that it helped them prepare for their scan.

All patients were booked with enough time to have a conversation both before and after the ultrasound. There was a room within the building for staff to have private conversations with patients. Chaperones were readily available for all intimate scans and procedures.

Understanding and involvement of patients and those close to them

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

We saw that patients were given clear information by email before their appointment. All patients we spoke with told us they felt well informed and prepared before coming for their scan. Patients could bring a friend or family member for procedures and certain interventions e.g. coil insertion.

On the day of the inspection we saw that staff communicated with patients in a way they understood. Staff took time to explain the procedure before and during the scan/intervention. After the procedure, patients were given enough time to ask questions and staff answered all questions in a calm, friendly and respectful manner. The sonographer explained the findings of the scan to the patient during the appointment and checked that they were able to receive the full written report by email, usually later that same day. This process was not audited so we could not verify. Patients were able to ring the service at any time, with any clinical issues triaged by the receptionist team to the consultant, who would call them back to discuss any concerns or issues.

There was no written information on the pricing structure available as the service was 'paperless'. There was pricing information available on the service website.

Are diagnostic imaging 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 the women using the service.

Evening and Saturday clinics were put on at short notice to fit around the patient. The service offered a range of examples of putting in extra time to support patients who required it, such as anxious patients.

The service was located close to public transport links and was accessible to the population of London and the surrounding areas, and those further afield, including people living overseas.

Good

Diagnostic imaging

Patients could book appointments online or over the telephone but most of the time, they were referred by a GP or consultant. The service offered out of hours appointment times, in the evenings and on Saturdays.

The ultrasound rooms were calm and relaxing.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. They coordinated interventions with other services and neighbouring independent health providers.

All staff had completed an equality and diversity course as part of their mandatory training. The service was accessible to all, including wheelchair-users, as there was a lift available for use.

The service rarely treated anyone with dementia or a learning or physical disability. There was no written policy at the service regarding patients with enhanced needs and no admission criteria that specified whether these patients would be seen at the service. When screening new patients, the service would ask if a patient required use of the lift, if so, they asked them to bring an adequately sized wheelchair if they used one.

Water and hot drinks were available in reception.

The service often treated patients from overseas. If applicable, those patients would bring their own interpreter that was provided by their nation's embassy. If the patient did not have access to interpreter services, the service used a telephone interpreting service. The service did not use family members to interpret.

Access and flow

People could access the service when they needed it and received the right care promptly. The service audited waiting times to ensure that all patients were seen within 20 minutes of arrival.

Patients could be referred by a primary physician but also could self-refer either by telephone or email. Staff planned admissions in advance at a time to suit the patient. The patients we spoke with told us they had not experienced any delays in agreeing a consultation appointment or setting procedure dates. On the day of inspection, we saw patients arrive in the reception area and wait no longer than ten minutes for their scan.

The sonographer gave the results of the ultrasound scans to patients immediately after their scans. Reports were also sent to patients by email within 24 hours of their scan.

Did not attend (DNA) rates were at 5%. All these patients were contacted to find out the reason for the DNA. The team called or texted every patient two days before the appointment to remind them.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigations of their complaint. However, we saw no information around the service or on the service website on how to complain.

We saw the service complaints policy, which stated that all complaints of a minor nature should be raised verbally with the clinic director. Formal complaints were made to the registered manager. All complaints were investigated by the clinic director. The policy stated that complaints would be acknowledged within two working days and resolved within 20 working days. At our last inspection, we found that the complaints policy referred the complainant to the Care Quality Commission (CQC) for escalation if they had an issue that could not be resolved. We advised at our last inspection that CQC do not have the powers to investigate individual complaints. The service since removed this information from their policy.

The service received no formal complaints in the twelve months before our inspection. It received three complaints in 2018 with no recurrent theme. The complaint audit did not provide information on the time length it took to resolve the complaints and whether it was within policy guidelines.

We saw no information throughout the service on how to complain. There was no information on how to complain on the service website. All the patients we spoke with during the inspection saw no reasons to make a complaint and could not suggest any improvements the service could make.

Good

Diagnostic imaging

Are diagnostic imaging services well-led?

Requires improvement

Our rating of well-led improved. We rated it as **requires improvement.**

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The registered manager was also the nominated individual. He also worked at a large London NHS trust. All clinical staff reported to the registered manager. All secretarial staff reported to the clinic manager. All staff we spoke to told us leaders were visible and accessible, and they would be happy to approach them with any concerns. Staff told us they felt well supported by the registered manager, who they worked with on a regular basis. They were approachable and open to new ideas and suggestions for improvement to the service.

Vision and strategy

The service had a vision but did not have a formal strategy to turn into action.

The service did not have a formal vision, beyond providing 'quality care for patients'. There was no formal strategy. However, the registered manger did have plans to expand the service.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture.

Staff spoke highly of the working environment and felt supported in their job roles. Staff told us they felt supported, respected and valued. We observed good team working amongst staff and staff felt 'proud to work' at the service. Staff at all levels told us there was a 'no blame' culture and that they felt confident in expressing ideas to one another. Staff were aware of what the term 'duty of candour' meant and understood their responsibility to be open and transparent with patients when any incidents met the criteria.

The registered manager responded positively to feedback and showed a culture of willingness to learn and improve.

Governance

While leaders and staff were clear on governance processes, we found these were not fully embedded. Staff at all levels were clear about their roles and accountabilities but did not have formal opportunities to discuss service improvements.

At the time of inspection, we were not assured that there were effective structures, processes and systems of accountability to support the delivery of good quality, sustainable services. We found that the registered manager was aware of all governance systems and risks but there were no formal systems for monitoring this or sharing with all staff.

At our last inspection we found that the service had no system for maintaining policies and procedures to ensure they were up to date, version controlled and met national guidance. At the time of this inspection, we found that there were policies which were dated and referenced up-to-date national guidance. The service had made efforts to update policies since our last inspection but there were still policies that were missing. For example, the service did not have a policy on what to do in the event of a deteriorating patient or emergency or on the prescription of antibiotics.

There was an audit programme in place to provide assurance of the quality and safety of the service. Peer review audits were undertaken in accordance with recommendations made by the British Medical Ultrasound Society.

The service did not have regular minuted team meetings but relied on informal sharing of information as they were a small team. We were informed that there had been one team meeting the month before our inspection, but this was not minuted. One member of staff informed us that this had a 'team building effect'. We were informed that incidents and complaints were discussed informally whenever they occurred.

Good

Diagnostic imaging

The registered manager would invite application from colleagues that he had personally trained within the NHS. Once an invitation had been accepted, the clinic manager would ensure that the personnel files contained all relevant information on the consultant e.g. scope of practice form, indemnity insure, DBS etc. We reviewed the consultant human resource files and found that they were robust and contained all relevant information.

Managing risks, issues and performance

Leaders and teams did not always use systems to manage performance effectively. We saw evidence they did not identify and escalate relevant risks and issues or identify actions to reduce their impact.

At the time of our last inspection, we found the service did not have a risk register and not all staff were aware of the risks within the service. At the time of this inspection, we found that the registered manager and the clinic manager understood some of the risks to the service and service delivery. However, these risks had not been documented within a risk management framework. There was no live risk register being maintained at the service.

There was no back-up generator on the premises. The registered manager told us that a 'power-cut' was a risk to the service but was not likely to occur.

One of the HCAs also acted as the fire marshal. We saw that there were two fire extinguishers on the consulting room floor. All staff had received fire training.

Managing information

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.

As with our last inspection we found the service used electronic systems to forward confidential medical records.

All patients were emailed their scan reports through the company email, which was secure. We reviewed six incident reports from the last twelve months and found that six related to patient scans being sent to either the wrong email address or bouncing back due to the wrong email address being inputted. The service was aware that this posed the risk of patient information being sent to the wrong person. To mitigate this risk, the service ensured that two members of staff checked the email addresses prior to reports being sent.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services.

The service had an easily accessible website where patients were able to leave feedback and contact the service. However, there was no information about how patients could make a formal complaint.

Staff actively sought feedback from patients through an online survey.

Due to the small nature of the service, there was no formal mechanism for receiving staff feedback. Staff told us that they would be comfortable suggesting improvements to the service and sharing thoughts on service delivery.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

The registered manager at the service had pioneered various approaches to scanning and worked with the manufacturers of the scanning machine to test new devices.

The service was keen to expand and was seeking advice to transition the leadership of the clinic.

Outstanding practice and areas for improvement

Outstanding practice

- The registered manager at the service had pioneered various approaches to scanning and worked with the manufacturers of the scanning machine to test new devices.

Areas for improvement

Action the provider MUST take to improve

- The service must develop formal opportunities to discuss and learn from incidents, complaints and audit results.
- The service must maintain a live risk register and a formalised risk management framework.

Action the provider SHOULD take to improve

- The service should provide evidence that it knows how to cope in the event of an emergency and produce a version controlled policy for the transfer of patients in the event of an emergency.
- The service should ensure it has a version controlled policy on the prescription of prophylactic antibiotics to ensure this is always done in line with best practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance