Private Ultrasound Limited

1-7 Harley Street

Inspection report

1-7 Harley Street
London
W1G 9QD
Tel:

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

Ratings

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

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients and removed or minimised risk where possible.
- Staff provided good care and treatment, gave patients enough to drink, and checked if they were comfortable during their scans. Managers monitored the effectiveness of the service and made sure staff were competent. 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 understand their scan results. They provided emotional support to patients where necessary.
- The service planned care to meet the needs of their patient population and took account of most patients' individual needs. People could access the service when they needed it and did not have to wait too long for an ultrasound scan.
- Leaders ran services well using reliable information systems. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. The service engaged well with patients and all staff were committed to improving services.

However:

- We found the policies were not up to date and did not reference national guidance. During the last inspection, the absence of referencing to national guidance was highlighted as an area the service should take action to improve. On this inspection, we found this had not improved. We raised this with the registered manager who admitted lack of oversight and following the inspection, addressed this.
- Although the service had two trained staff to act as chaperones, it was identified that additional staff considered to act as chaperone in exceptional circumstances should also receive the necessary training.

Victoria Vallance

Director of Secondary and Specialist Healthcare

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 main activity at this service. See the overall summary for details.

Summary of findings

Contents

Summary of this inspection

Background to 1-7 Harley Street

1 to 7 Harley Street is operated by Private Ultrasound Limited. Most patients accessing the service self-refer to the clinic and are all seen as private (self-funding) patients.

The service has a registered manager in post. A registered manager is a person who has registered with the CQC to manage the service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service provides diagnostic imaging (ultrasound scans only) for patients aged 18 years and 65 years. The service provides pregnancy ultrasound, gynaecological and fertility scans for women, as well as liver, upper abdominal, kidney, bladder and prostate scans for patients. The service no longer provides pregnancy nuchal fold thickness scans and non-invasive prenatal testing (NIPTS).

The service leases one clinic room situated on the first floor of a building containing other separately registered healthcare providers.

Activity between January 2022 to December 2022:

- In the reporting period, a total of 1250 scans took place at the service. Of these, 750 were pregnancy growth scans, 38 were anatomy pregnancy scans, 375 were early pregnancy scans, 225 growth and Dopplers scans in 2D or 3D , 38 anatomy scans, 112 reassurance and growth scans, 250 were liver and abdomen scans, 100 neck scans (including thyroid, lumps, bumps, carotid scans), 50 hernia scans, 50 testes scans and 50 pelvic scans.

Track record on safety for the period 2022 to December 2022:

- Zero never events.
- Zero clinical incidents.
- Zero serious injuries.
- Zero complaints.

Services provided at the service under service level agreement:

- Provision of the clinic room, including cleaning
- Waste removal
- Maintenance of ultrasound equipment

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. Our inspection team was led by a CQC lead inspector and an assistant inspector.

How we carried out this inspection

We reviewed documents that related to the running of the service including policies, equipment checks, meeting minutes, five ultrasound reports, staff training records, results of surveys, audits and patient feedback.

Summary of this inspection

We interviewed all staff members including the registered manager, lead sonographer and both of the contracted consultant radiologists. We spoke with four patients but were not able to observe any scans as the patients did not consent to this due to wanting their privacy. However, patients were happy to speak with us after their scans.

We carried out a short-announced inspection on 17 January 2023.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

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

Action the service SHOULD take to improve:

- The service should ensure that policies and protocols are reviewed and updated in a timely manner going forward.
- The service should ensure the clinic's website reflected the scans provided and remove scans such as nuchal folds and non-invasive prenatal tests (NIPTS), which were no longer provided.
- The service should ensure that additional staff considered to act as chaperone when required receive the necessary training.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Diagnostic imaging

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

Are Diagnostic imaging safe?

Good

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

Mandatory training

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

Staff received and kept up to date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. The training was delivered via an e-learning platform by an external provider.

Mandatory training subjects included: infection prevention and control, fire safety, equality and diversity, safeguarding adults and children, consent, adult resuscitation, conflict resolution, moving and handling, information governance, complaints handling and health, safety and welfare. As of January 2023, the mandatory training compliance for all permanent staff was 100%. The registered manager told us they received renewal prompts from the digital platform when staff needed to update their training.

The two consultant radiologists completed their training with their substantive NHS trust employers. We saw evidence they had completed and were up to date with all required mandatory training. The registered manager kept a record of their training and asked for annual updates to add to their files.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. The service did not see any patients under the age of 18. Mandatory training included safeguarding training and all staff were 100% compliant for safeguarding adults (level one and two) and children (level one).

The service had a safeguarding policy which staff were aware of and knew how to access. During the last inspection, we found that although female genital mutilation (FGM) was covered in safeguarding training, the safeguarding policy did not reference FGM. On this inspection, we found the service had addressed this. We saw evidence that the safeguarding policy had been amended to include FGM. Staff demonstrated awareness of FGM and told us that the service had not seen any cases of FGM.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The registered manager could access advice from the Local authority safeguarding teams if needed. Staff were able to provide an example of a safeguarding concern which was referred appropriately to the local authority and logged on the incident reporting system.

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. Clinic staff kept equipment and the premises visibly clean.

Hand gel was available in reception and in the clinical area. There were signs at the entrance to encourage patients and visitors to use the hand gel. The service had personal protective equipment (PPE), including aprons and gloves available and these were seen in the clinic.

The clinic room was visibly clean and had suitable furnishings which were well-maintained. The clinic room had washable flooring and wipe-clean furnishings. The service used fresh paper towelling on the couch for each patient. We saw a hand sanitiser placed in a prominent position in the scanning room. Staff informed us they followed infection control principles including the use of PPE when performing intimate examinations. Staff used single use sterile gel for scans and showed us the sachets as evidence. Each sachet had enough gel for one patient.

There was a handwash basin in the clinic room and access to hand disinfectant. Handwashing guidance was displayed above the basin to remind staff of best handwashing techniques.

Staff correctly cleaned and stored equipment such as probes used for intimate ultrasound investigations (for example, transvaginal investigations). Staff covered the probes with an appropriate sheath during investigations and cleaned them with the recommended sporicidal wipes after each ultrasound scan. This eliminated the risk of cross-infection between patients. The service kept a cleaning record book which documented the cleaning of the ultrasound probes. We reviewed the record book and found it had been fully completed and signed with the appropriate labels attached.

During the last inspection, we found that although the service did not perform any blood tests or wound care, they did not have the spill kits to clean blood or other bodily fluid spillages. On this inspection we found the service had addressed this and had acquired a spill kit.

Staff knew how to report and escalate any concerns with cleanliness appropriately. Staff told us that the management staff for the premises completed the cleaning audit for the site. Deep cleaning of the clinic room was also completed by the landlord on a monthly basis and we saw evidence to demonstrate cleaning had taken place. In addition to this, the service completed weekly steam cleaning of the clinic room.

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

Good

Diagnostic imaging

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 service was located on the first floor and there was secure access to the clinic. The service had one clinic room, a shared waiting area and two toilets which they rented from the premise's landlord. Staff told us that they could easily contact the management team for the landlord if there were any issues on site. The clinic room had a television on the wall in order to show and discuss the scanned images with the patients.

The service had systems to ensure machines or equipment were repaired on time, when needed. The service had two ultrasound machines in the clinic. One machine was new and had been acquired in December 2022. Staff told us that the ultrasound machine's manufacturer maintained and serviced the machine annually. We reviewed service records for second machine, which detailed the maintenance history and service due dates. The next service was due in September 2023.

The service had safe arrangements for the handling, storage and disposal of clinical waste in accordance with HTM 07/01 The Safe Management of Healthcare Waste 2013. Clinical waste bags were collected under contract with an external company. The service did not use sharps such as needles, as they directed patients to other separately registered services for any blood tests.

Due to the nature of the service they did not require a resuscitation trolley. However, they did have access to a first aid box.

Fire extinguishers checks and weekly fire alarm testing was completed by the premise's landlord. We saw that fire extinguishers were available on the first floor and were in date. The registered manager was aware of the evacuation procedure in the event of a fire. The service had an escape stretcher in case of collapse or fire emergency which was readily accessible.

Assessing and responding to patient risk

Staff removed or minimised risks where possible. Staff identified and quickly acted upon patients at risk of deterioration.

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 the case of emergency, the patient would be transferred to the most appropriate neighbouring NHS hospital, using the standard 999 system.

Staff described what actions they would take if they found unusual findings on an ultrasound scan. Once the sonographer identified an abnormal scan, they created a report which clearly outlined their concerns. In the case of an acute abnormality, the patient was instructed to attend their nearest emergency department with a copy of the report. Staff had completed training in breaking bad news.

In the case of any other abnormal result, a copy of the scan report would be given to the patient for their NHS notes and the sonographer would ring and speak directly to the patient's GP or appropriate healthcare professional. Staff gave us examples where patients and healthcare professionals had provided feedback about positive patient outcomes as a result of the service's intervention.

Good

Diagnostic imaging

The service ensured the right person got the right scan at the right time, by asking patients to confirm their identify and date of birth. This evidenced staff followed best practice and used the British Medical Ultrasound Society's (BMUS) 'pause and check' checklist.

The service accepted patients between 18 and 65 years of age and staff told us that the clinic did not see clinically ill or complex patients as most patients self-referred for private scans.

The sonographer reported they had not had patients who requested frequent scans. They advised any patients who wanted longer appointments that their scanning time was restricted to 10 -15 minutes as per the BMUS guidance and followed the as low as reasonably achievable (ALARA) principles, outlined in the 'guidelines for professional ultrasound practice 2021' by the Society and College of Radiographers (SCOR) and BMUS.

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.

The service had one registered manager and one lead sonographer who completed most of the scans. The sonographer had completed a medical ultrasound degree level course which we saw evidence of on inspection. The service had two consultant radiologists employed on a locum basis who conducted specialist clinics on Wednesdays and Fridays as patient demand required. We were told there was usually a second member of staff present, who was normally the lead sonographer. Staff told us that if at any point the consultant radiologist's opinion or follow up was needed, they could be contacted at any time or asked to rescan a patient.

The registered manager told us there were no plans to recruit any additional staff. Both staff we spoke with felt the staffing levels were sufficient to cover the work required. The service's sickness rate from January 2022 and December 2022 was 0%. Although the service did not use bank and agency staff between January 2022 and December 2022, the registered manager told us they could use an agency they had used previously if needed.

Between January 2022 and December 2022, the service had not cancelled any appointments due to staffing.

Records

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

Patients received a signed ultrasound report which was written by the sonographer or consultant radiologist at the time of the scan to add to their NHS notes. Where appropriate, and with consent, the sonographer could also send a copy of the scan report to the patient's general practitioner. All electronic reports were emailed directly from the ultrasound machine through a secure and encrypted mail platform.

Scans and ultrasound reports were saved on the ultrasound machine which was password-protected and kept in the locked clinic room at all times. Staff archived the images and reports regularly from the ultrasound machine onto an encrypted external hard drive and stored this securely in a locked cupboard.

We reviewed five ultrasound reports. Staff recorded information in a clear format. This included the reason for the scan, the findings and recommendations. Although there was no formal record of any pre-existing medical conditions in the reports, staff told us that this information was requested on the booking form. The information provided was confirmed during the appointment when a verbal history was obtained.

Good

Diagnostic imaging

The service did not routinely keep any paper records except for the completed written consent forms for transvaginal scans. Some referral letters were received and were kept in a locked cupboard alongside completed consent forms within the clinic room.

Medicines

The service did not store or administer any medicines.

Incidents

Staff knew what incidents to report and how to report them. Managers told us they would investigate incidents and share lessons learned with the team. Staff had knowledge or understanding of duty of candour

The service used a paper-based reporting system, with forms available in the clinic for staff to access. The registered manager would be responsible for handling investigations into all incidents.

From January 2022 to December 2022, no incidents were reported at the clinic. Staff we spoke with knew how to report incidents and could give examples of when they would do this. The registered manager told us they would investigate any incidents and share lessons learned with the team in person or would arrange a meeting if necessary. We reviewed the incident reporting policy which was in date and described how incidents should be reported and graded.

In accordance with the Serious Incident Framework, the service reported no serious incidents (SIs) from January 2022 to December 2022.

During the last inspection, we found that staff were not familiar with the requirements of duty of candour. On this inspection, we found this had improved as staff we spoke with demonstrated awareness.

Are Diagnostic imaging effective?

Inspected but not rated

We do not rate effective for this type of service.

Evidence-based care and treatment

The service provided some care and treatment based on national guidance and evidence-based practice. Although we found policies and protocols out of date without reference to national guidance, the registered manager addressed this immediately after the inspection and provided the necessary evidence.

During the last inspection, the CQC identified to the service that they should review their existing policies and add in references to national guidance where appropriate. On this inspection we found this had not improved. We found policies such as infection prevention and control, emergency protocol and consent were out of date in April 2022 and did not reference national guidance.

We raised this with the registered manager who admitted lack of oversight and addressed this immediately and provided the necessary evidence. After the inspection, we reviewed the 15 protocols and 16 policies provided and found they were in date, had version controls and referenced national guidance such as National Institute for Health and Care Excellence (NICE), the Royal College and Society of Radiographers, the foetal abnormality screening programme (FASP) standards or the British Medical Ultrasound Society (BMUS) where appropriate.

The service followed as low as reasonably achievable (ALARA) principles outlined by the Society and College of Radiographers. The registered manager told us frequent scans did not occur and scans were time limited.

Nutrition and hydration

Staff gave patients enough to drink to meet their needs.

Staff told us that confirmation emails sent to patients included instructions regarding fluid and food intake ahead of their scans. Staff gave women information on drinking water before a fertility or pregnancy scan to ensure they attended with a full bladder which enabled the sonographer to gain a better view of the womb. Staff advised patients to fast for four hours ahead of gall bladder scans and where patients were diabetic, they were advised to maintain their sugar levels with a sugary supplement.

Patients had access to drinking water in the reception area. The service offered water to patients who were required to have a fuller bladder at the time of the scan.

Pain relief

Staff checked to ensure patients were comfortable during their scans.

Staff did not formally assess pain levels of patients as the procedure was pain-free. However, staff told us they would check frequently with patients if they were in pain or discomfort during their scans.

Patient outcomes

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

The service performed twice yearly audits of general ultrasound images and obstetrics. The consultant radiologist randomly selected 20 records from the external hard drive and reviewed the images and reports for quality, feeding back directly to the lead sonographer. We reviewed the ultrasound clinical audit for obstetrics for December 2022 which showed that the quality of the scans and reports written by the lead sonographer were good with accurate diagnostic value and recommendations for further treatment and investigations.

When staff identified any unusual or abnormal images needing further referral to specialists, they told us they could follow up the outcomes to assess the accuracy of the diagnoses through a telephone call or email communication. Staff told us that they often received feedback directly from patients confirming their scan results and what further procedures they underwent following their appointments. We spoke with one patient who told us how their initial scan resulted in referral for additional diagnostic tests which confirmed the findings by the lead sonographer.

Good

Diagnostic imaging

The consultant radiologists gave us examples where the lead sonographer received positive feedback from general practitioners (GPs) and other healthcare professionals for the quality of the gynaecology scans and the positive patient outcome as a result. The service gave us examples where the findings from scans in the clinic allowed patients to get the necessary treatment which maximised their chances of conceiving.

Competent staff

The service made sure staff were competent for their roles. The service checked medical staff received appraisals.

During the last inspection, we found the service did not have a formal record for inductions for new staff. Although the service had no plans to recruit additional staff, we found on this inspection, the service had introduced a new starter induction welcome pack which included references to policies and protocols, infection prevention and control (IPC), building and fire regulations including emergency evacuation and complaints. The registered manager told us that new staff would be supervised and guided for at least three sessions before being allowed to work independently.

Both consultant radiologists had an annual competency assessment and appraisal within their substantive posts in their NHS trusts. The registered manager ensured that both consultant radiologist provided up to date evidence of this. We saw evidence of completed and in date mandatory training, competencies and appraisals for both consultant radiologists.

During the last inspection, we found the service did not conduct formal appraisal of staff. On this inspection, we found the service had an appraisal process for permanent staff. As of January 2023, the service reported an appraisal rate of 100%. As part of the lead sonographer's appraisal, a sample of their scans were reviewed by the consultant radiologist to ensure the quality of their scans, findings and ultrasound reports. The consultant radiologist described the lead sonographer as well trained and competent in their techniques.

We saw confirmation of the lead sonographer's registration with the public voluntary register of sonographers and various competencies. This included specialist licenses for Nuchal Translucency screening from Foetal Medicine Foundation as well as the United Kingdom Collaborative Trial of Ovarian Cancer Screening (UKTOCS) Ovarian Cancer Screening. The lead sonographer gave us multiple examples of conferences and study days they had attended in the last year to keep up to date with best practice in medical ultrasound and baby scans. The lead sonographer told us they were aware of the recent guidance for competencies for ultrasound practice in private baby scan clinics by the Society of Radiographers (SoR) (October 2022) and told us they had received an email from SoR to provide their feedback.

Multidisciplinary working

Staff worked together as a team to benefit patients. They supported each other to provide good care.

Staff told us there were positive working relationships between all individuals as the service was run by a small team. The lead sonographer carried out baby scans and attended clinics with the consultant radiologists to support them.

The service reported good working relationships with locally registered private general practitioners (GPs) and obstetricians. Staff told us they received letters with positive feedback from these providers regarding patient satisfaction with their scanning experience.

Good

Diagnostic imaging

The service told us that where the patient had consented for their information to be shared, GPs and other healthcare professionals could receive a copy of the ultrasound report and scanned images. Patients were given a hard copy of their ultrasound report at their appointment.

The lead sonographer and consultant radiologists made recommendations for further diagnostic tests within the ultrasound report. This included requests to the GP to action any necessary referrals such as computerised tomography (*CT*) *scan*s and clinician recommendations if the patient wished to access private healthcare.

Seven-day services

Key services were available six days a week to support timely patient care.

The service operated up to six days a week, dependent on patient demand. The service was operational on Monday, Tuesday and Thursday from 10am to 6.30pm (with a break between 3pm to 5pm), Wednesdays 10am to 3pm and Fridays 12 to 6.30pm. In addition, the service offered appointments between 10am and 2pm on Saturdays. The main reception was open 8.30am to 5.30pm.

Staff told us that patients could contact the service by email or via telephone with the option to leave a voice message. The service responded to most calls within 24 hours.

Health promotion

Staff gave patients advice in relation to their procedure.

The provider's website had patient information on the diagnostic imaging procedures available. Patients were provided with information on what actions they needed to take prior to their scan.

Due to the nature of the service, although lifestyle advice was not provided, the service made recommendations for further diagnostics where required.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment.

There was no separate written policy relating to the Mental Capacity Act (2005), although capacity to consent was covered in the clinic's consent policy. Staff were able to verbalise the process to take when they had concerns around a patient's capacity to provide consent, which was in line with the service's consent policy. However, staff told us that as they offered a private service with the majority of patients self-referring, they had never had an incident of a patient lacking capacity to consent.

All patients were directed to read the provider's website for information about their scan. All staff were aware of the importance of gaining consent from patients before conducting an ultrasound scan. The sonographer confirmed names and dates of birth prior to the scan and obtained verbal consent to begin external scans. Patients we spoke with confirmed that they had received all the information ahead of the scans and verbal consent was taken ahead of scans.

Good

Diagnostic imaging

Although the service did not record verbal consent in reports, all patients receiving an internal scan (such as transvaginal scans), were required to complete a written consent form. We reviewed the consent form for transvaginal scans which included patient's information on the scan, chaperone requirements and patient consent. We saw evidence of signed copies which were stored securely in the clinic. Consultant radiologists told us they followed a similar practice with their substantive employer with regards to not recording verbal consent on reports for external scans. Where patients agreed to proceed with external scans, this was considered implied consent.

Are Diagnostic imaging caring?

Good

We did not rate caring at the last inspection but on this occasion, 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.

The following was representative of feedback from patients and their families and carers: "Professional expertise at affordable prices and on the spot reassurance for medical queries", "They are professional, efficient and experts", "I am always confident and reassured by her evaluation and assessments", "Thanks to Dr [X] for putting my mind at ease when we were given a confusing diagnosis from NHS during my pregnancy" and "Times when I've been let down by delays through the NHS, the clinic always reassuringly comes through".

We were not able to directly observe any scans as the patients did not consent to this due to wanting their privacy. However, patients were happy to speak with us after their scans. Patients we spoke with described the staff as nice, kind, very thorough and reassuring. Patients felt they were listened to and understood. One patient had looked for the lead sonographer specifically as they had a positive experience with them previously.

The sonographer told us they introduced themselves before a patient's scan, explained their role and what would happen next. Patients we spoke with told us staff were "professional" and they explained everything once they were in the room. Patients told us they would recommend the service to their family and friends.

The registered manager told us they directed people to leave feedback on their website, or through an internet search engine review function. As of January 2023, the majority of the 102 reviews on this platform were positive, with the clinic scoring 4.6 out of five overall.

All conversations during and after an appointment took place in the private clinic room. Patients were greeted at the reception by the building's receptionist and collected from the waiting room and taken up to the clinic room by staff.

The female registered manager acted as a chaperone during intimate examinations. A chaperone is a person who serves as a witness for both patient and clinical staff as a safeguard for both parties during an examination or procedure. The clinic always ensured two staff were on a shift together and the registered manager told us any gynaecological or pregnancy scans would be rescheduled if a second member of staff was not available.

The registered manager told us that on one exceptional case, the reception staff did act as a chaperone having been briefed and provided with all the relevant information. Although this was an exception, if the service planned to use the reception staff more for chaperoning, the registered manager told us they would ensure that the staff have appropriate training to do so.

Emotional support

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

Patients were given 30-minute appointments which meant there was enough time for questions as scans were completed in much less time than this. Staff explained how they would provide reassurance and support for nervous and anxious patients.

Patients we spoke with during the inspection told us that they received all the information they needed and were able to ask any questions. Patients told us they felt listened to and their questions were answered fully. Patients described the sonographer's explanation of their scan results as helpful which alleviated the anxiety they felt before attending the appointment.

The lead sonographer described how they would explain distressing findings to the patient following a scan, with sensitivity and the appropriate level of detail. They explained they would flag any abnormal results and would refer the patient to NHS care or ongoing specialist care. The GP or health professional could then make further investigations based on the findings of shared report, with the patient's consent.

Staff described how they would comfort any patients in distress. Staff told us there was a small private coffee room that patients could sit in if distressed, and they would ensure any patients receiving bad news were given the opportunity to call someone to accompany them when leaving the service. Staff told us that where patients had received bad news, the service delayed the payment and sent an invoice after the appointment as the patient was already distressed.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their scan results.

Patients were directed to the service's website and given verbal information where necessary to prepare for their scan. Essential information was sent by email if preferred by the patient. All costs were clearly stated on the provider's website and confirmed with the patient before a scan being booked.

The sonographer explained the findings of the scan to the patient during the appointment and gave them a copy of the full written report. Patients were able to ring the service at any time to discuss or clarify any issues or email any queries. If patients called during hours the service was closed, they were able to leave a message and staff would call them back to discuss any concerns or issues.

The service allowed partners and relatives to be present in the scanning room and described how they sometimes had a few family members present to observe baby scans.

Good

Diagnostic imaging

Are Diagnostic imaging 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 patient population.

The clinic's location was close to public transport links. The service provided information on travelling to the clinic on their website. Patients told us it was very easy to make an appointment. Patients told us they had the necessary information ahead of scans including cost.

Patients reported to the main reception desk on the ground floor before being collected by a staff member. The clinic was on the first floor and was accessible by stairs. The scanning room could comfortably accommodate two members of staff, the patient and any relatives who wished to be present. It included a scan couch and some chairs. There was one large screen to view the images.

The service had a range of packages with different price options which it clearly displayed on the website. Patients could book appointments online through a secure portal. The service offered out of hours appointment times, in the evenings and on Saturdays.

Meeting people's individual needs

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

Most of the patients self-referred for private scans at the clinic which meant the service did not see clinically ill patients. Although staff had knowledge of patients living with dementia and patients with learning disabilities, they told us the clinic had not seen any patients living with dementia and learning disabilities. Staff told us they would signpost patients to other services where they were unable to accommodate them.

The clinic room provided a calm and relaxing atmosphere. The room had dimmed lighting to enable the patient to view the images. There was appropriate space within the building for staff to have private conversations with patients. Patients we spoke with told us they received the necessary information they needed on the procedure and what to expect before attending the service. Patients told us they were given enough time to ask questions and staff answered all questions in a calm, friendly and respectful manner. Patients we spoke with told us they would use the service again.

Although the clinic did not have wheelchair access as there was no lift in the leased building, staff signposted patients to other services when they were unable to accommodate them.

Staff had completed the equality and diversity course as part of their mandatory training. During the last inspection, the CQC identified to the service that they should consider how to improve access to formal translation and interpretation services. On this inspection, although we found this had been addressed as the service could access formal translation and interpretation services easily, staff told us that they had not needed to access this as most patients spoke English.

Staff told us they had access to Arabic interpreters working in the area if needed. Staff said they encouraged patients to bring friends or relatives with them if English was not their first language which was not in line with best practice. The clinic manager acknowledged there was a risk with this approach however felt that it was proportionate for their type of service.

The service offered various pregnancy scans which included early pregnancy scan, gender scan at 16 weeks, reassurance scans at any point, anomaly scan at 20 weeks, 2D/3D images and growth and doppler scans. Although many patients booked scans for reassurance, staff told us they reminded women to still attend their NHS appointments when they attended the clinic. Although the service no longer provided nuchal fold scans and non-invasive prenatal tests (NIPTS), the service provided patients with information on the Harmony test (which was the most proven brand of NIPTS) and signposted patients to nearby clinics who offered the test. The registered manager told us that the website was in the process of being updated to reflect this and the online booking form did not allow patients to book this scan.

Although the service did not see any cancer patients, the service did offer ovarian cancer screening.

Access and flow

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

The clinic provided a private service on request of the patient either by self-referral or on referral from another clinician. The service did not have a waiting list for ultrasound appointments. Patients could book appointments online easily. Where this was not possible, the scan would be booked the following day, or whenever was most convenient for the patient. The registered manager explained the booking system was flexible and allowed changes to packages to meet patient choice. Patients paid a small deposit upon booking the scan and staff told us this helped manage do not attend rates. During the inspection, we spoke with two patients who had booked the scan on the day an hour or so before attending.

The sonographer gave the results of the ultrasound scans to patients immediately after their scans, along with a copy of the written report. The report contained images of the scanned areas and any further recommendations.

The consultant radiologists conducted specialist clinics on Wednesdays and Fridays in line with patient demand and provided advice and guidance where required. Recommendations for additional diagnostics tests were made where necessary in the ultrasound report.

Staff told us that patients did at times cancel scans due to various factors which the service either rescheduled or refunded deposits. Reasons included miscarriage, premature birth or personal travel arrangements. Although cancellations did not occur frequently, the registered manager told us that there were 10 scans cancelled between January 2022 and December 2022.

Although the service did not formally audit patient waiting times in the clinic, on the day of inspection, we saw patients arrive in the reception and wait no longer than five minutes for their scan.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service had not received any complaints in the last year. However, there were policies and procedures in place to ensure concerns and complaints were treated seriously, investigated, and lessons learned would be shared.

Good

Diagnostic imaging

Staff told us they would deal with complaints informally in the first instance, with attempts made to resolve the complaint locally. In the case of a formal complaint, the service had a policy for handling complaints and concerns, which was in date. The policy stated complaints would be acknowledged within two working days, and the service would provide a full response within 10 working days. Where the investigation was still in progress, a letter explaining the reason for the delay would be sent to the complainant and a full response made within five working days of a conclusion being reached.

Staff had completed mandatory training on complaint handling. The registered manager told us they would share learning from complaints informally in person or by email, with a team meeting organised if required. The registered manager informed us the service had received three complaints between January 2022 to December 2022 of which none were upheld. The registered manager told us what each complaint was about and explained why they had been withdrawn as a result of investigation. For example, one complaint was regarding the service not providing a scan for patient. However, investigations showed that the booking had been made under the parent's name and the patient who presented for a scan was 17 years old. As the service was only registered to provide scans for patients between 18 and 65 years of age, they were unable to provide a scan and had to signpost them elsewhere.

During our last inspection, we found the provider's website and clinic environment did not include information for patients on how to make a complaint. On this inspection, we found this had been addressed and we saw the evidence for this both on the website and onsite.

Are Diagnostic imaging well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the integrity, 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.

The non-clinical practice manager was the registered manager for the service. The registered manager and lead sonographer worked closely together to run the service and felt well supported by one another. At the time of the inspection, the service contracted two consultant radiologists on a locum basis. We spoke with both consultant radiologists who described the leadership of the service as well organised, approachable and visible.

Due to the limited nature of the service, there was no role extension planned for staff within the service.

Vision and strategy

The service had a vision and a mission statement for what it wanted to achieve.

The clinic had a mission statement, which stated that the priority was to offer the best quality care at the most affordable prices, in order to ensure a wide section of the population had access to their scanning service. The clinic strived to exceed patient expectations by providing an experience that was consistently professional, personalised and caring.

Good

Diagnostic imaging

Through the best practice approach, the service had learned to anticipate their patients' needs more closely and had invested into equipment and best medical professionals. The service hoped to expand on their wide range of ultrasound services by adding further specialist scans. During 2022, the clinic had introduced full body ultrasound scans and hoped to offer a Breast Screening ultrasound in future.

Culture

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

Staff told us they enjoyed working at the service, and there was a friendly, supportive culture where people were happy to raise concerns or make suggestions. Staff promoted openness and honesty. We observed good team working amongst staff on the day of inspection and found there was an emphasis on patient centred care.

The registered manager reassured us improvements would be made at once following our feedback and demonstrated this by making changes immediately following inspection. This showed a culture of openness and willingness to learn and improve.

Governance

Leaders did not operate wholly effective governance processes. Staff were clear about their roles and accountabilities. Staff had regular opportunities to meet, discuss and learn from the performance of the service.

We found the policies were not up to date and did not reference national guidance. During the last inspection, the absence of referencing to national guidance was highlighted as an area the service should take action to improve. On this inspection, we found this had not improved. We raised this with the registered manager who admitted lack of oversight and following the inspection, addressed this. (Refer to evidence based care and treatment subheading).

The service had systems and processes to support the delivery of a safe and caring service. All staff had regular criminal safety checks (Disclosure and Barring Service checks) and completed mandatory training appropriate to their role.

During the last inspection, we found the service did not have regular formal team meetings but relied on informal sharing of information as they were a small team. On this inspection, we found this had been improved. The service had regular monthly team meetings where they could suggest improvements to the service. Attendees included both consultant radiologists, registered manager and lead sonographer. We reviewed the staff meeting minutes between July 2022 and December 2022 and found there was discussion on annual leave, patient cases, activity levels for the service, upcoming professional conferences, patient feedback, website and equipment. The consultant radiologists told us that new protocols and guidance would also be discussed at these meetings where needed.

Staff understood their roles and only carried out scans in line with their competencies. The service had indemnity and medical liability insurance which covered all staff working within the service for the case of a legal claim.

Managing risks, issues and performance

Staff used systems to manage performance effectively. They identified and managed relevant risks and issues and identified actions to reduce their impact. The service had plans to cope with unexpected events.

Good

Diagnostic imaging

The registered manager and sonographer understood the risks relating to the premises, service delivery and business. There was evidence the registered manager and sonographer had identified and mitigated the risks and documented these risks within a risk management framework, which was reviewed annually.

The service completed clinical audits to review current practice and drive improvement. For example, the quality of ultrasound scans performed by the sonographer were regularly reviewed by a consultant radiologist.

The service had a contingency plan, focusing on staff absence, premises and equipment failure. Although the landlord of the premises was responsible for the building maintenance including the weekly fire alarm tests and emergency lighting, the service obtained the necessary reassurance that this had been completed. The registered manager obtained up to date paperwork from the landlord for completed fire alarm service testing, emergency lighting servicing worksheet, legionella risk assessment report and *portable appliance testing* (PAT) certificate. All permanent staff including the locum consultant radiologists had completed fire safety awareness training.

Although the premises did not have an emergency backup generator, staff told us there was limited impact on the service as scans could be rearranged if necessary. In the event of a power cut, any scans would be terminated and rebooked. In addition, if any scans were perceived as urgent (which was unlikely due to the nature of the caseload), the patient would be advised to attend the nearest NHS centre.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats. The information systems were secure.

Staff had access to all the information they needed through their laptops. Staff were aware of how to use and store confidential information. Staff had completed training on information governance and data security as part of mandatory training. Staff told us that the ultrasound machine had a function that could hide any patient details when reviewing scans and reports.

The ultrasound machine was password protected. All patient images and reports were regularly archived on an external hard drive that was locked away and password protected. The registered manager stored printed referral letters and completed consent forms in a locked filing cupboard in the locked clinic room. Both permanent staff members had access to the key.

The service outsourced an external company for support with the service's website and social media. Staff we spoke with told us they did not have any issues with information technology (IT) equipment or software.

Engagement

Leaders and staff engaged with patients and staff.

The service had an easily accessible website where patients were able to leave feedback and contact the service. The service used patient feedback to make improvements to the service. For example, patients had provided feedback that they were interested in full body scans at a reasonable price so that they could have all the relevant scans done at once. As a result, the service introduced a full body scan which was better value for money.

Good

Diagnostic imaging

Although there was no formal mechanism for staff feedback due to the small size of the team, staff had regular monthly team meetings where they could suggest improvements to the service.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

Staff attended conferences appropriate to their roles, for example, the lead sonographer attended conferences and study days for best practice in medical ultrasound and baby scans.