Discovery Ultrasound Kent & Sussex Limited

Quality Report

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

Ratings

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

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

Services we rate

We rated it as **Requires improvement** overall.

We found the following issues that the service provider needs to improve:

- Not all staff had training in key skills and did not understand how to protect patients from abuse. The service did not manage safety incidents well and did not learn lessons from them. Staff did not collect safety information and did not use it to improve the service.
- The safeguarding policy for vulnerable adults was not up to date. The service did not have a safeguarding policy for children and young people.
- The manager did not correctly monitor the effectiveness of the service or make sure all staff were competent for all roles.
- The clinic lacked a robust approach to quality improvement.
- The manager did not run services well using reliable information systems.

However, we also found the following areas of good practice:

- The service controlled infection risks well. Staff assessed risks to patients, acted on them and kept good care records. The service had enough staff to care for patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs. People could access the service when they needed it and did not have to wait long for their scan.

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. Details are at the end of the report.

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South)

Overall summary

Discovery Ultrasound Kent & Sussex Limited is operated by Discovery Ultrasound Kent & Sussex Limited. The service has diagnostic facilities and offers pregnancy scans to self-referring private patients. The service provides fertility scans to aid conception and in conjunction with assisted conception. The service also provides baby bonding ultrasound scans to pregnant women and their friends and family.

The service employs one sonographer who is also the registered manager and a receptionist who is not based in the office. Another sonographer has a flexible contract to carry out a number of ultrasound lists every month.

We inspected this service using our comprehensive inspection methodology. We carried out the announced inspection on 08 November 2019. The inspection was announced in advance as the service opened depending on patient need.

Summary of findings

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.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Requires improvement 	Discovery Ultrasound Kent and Sussex Limited provides obstetric ultrasound scans to privately funded patients. In the last 12 months the service has scanned 1,238 women.

Summary of findings

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Requires improvement

Discovery Ultrasound Surrey and Sussex

Services we looked at
Diagnostic imaging

Summary of this inspection

Background to Discovery Ultrasound Kent & Sussex Limited

Discovery Ultrasound Kent & Sussex Limited is operated by Discovery Ultrasound Kent & Sussex Limited. The service opened in 2013. It is a private obstetric and gynaecology ultrasound service in Battle, East Sussex. The service primarily serves the communities of East Sussex. It also accepts patient referrals from outside this area. Women can attend this service from 18 years of age.

The service has had a registered manager in post since 2013.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector and another CQC inspector. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Information about Discovery Ultrasound Kent & Sussex Limited

The service has one clinic location and is registered to provide the following regulated activities:

- Diagnostic Imaging

During the inspection, we visited the clinic. We spoke with one member of staff. We spoke with three patients and seven relatives. During our inspection, we reviewed three sets of patient records.

There were no special reviews or investigations of the clinic ongoing by the CQC at any time during the 12 months before this inspection. This was the services first inspection since registration with CQC, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (November 2018 to October 2019)

- In the reporting period November 2018 to October 2019. There were 1238 ultrasound scans performed.
- Track record on safety
- Zero Never events
- Zero Clinical incidents
- Zero serious injuries
- Zero incidences of hospital acquired meticillin-resistant Staphylococcus aureus (MRSA),
- Zero incidences of hospital acquired meticillin-sensitive Staphylococcus aureus (MSSA)
- Zero incidences of hospital acquired Clostridium difficile (c.diff)
- Zero incidences of hospital acquired E-Coli
- Zero complaints

Services provided under service level agreement:

- Clinical and non-clinical waste removal
- Interpreting services
- Maintenance of medical equipment
- Maintenance of fire safety equipment

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

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

- One sonographer had not had the correct training on how to recognise and report abuse. The safeguarding policy for vulnerable adults was not up to date.
- The service did not have a safeguarding policy for children and young people.
- Although the sonographer recognised incidents, there was no system to report and learn from them.
- The service had not had a fire risk assessment at the time of inspection.

However:

- The unit was visibly clean, and staff adhered to infection prevention and control practices in their interactions with patients.
- There was a system in place to service equipment regularly and a contract to repair or replace in the event of equipment failure.
- The sonographer had the right clinical skills and experience to keep people safe from avoidable harm and provide the right care and treatment.

Are services effective?

- As a trained radiographer the sonographer had registered with the Health and Care Professions Council register.
- The sonographer understood their role and responsibility under the Mental Health Act 2005.

However:

- The sonographer was not knowledgeable about the consent process and did not always obtain consent in line with national guidance.

Are services caring?

Good

We rated it as **Good** because:

- All patients and relatives we spoke to were very positive about the service they had received and about the staff providing the service.
- We observed the sonographer being compassionate, respectful and providing emotional support to all who required this.

Summary of this inspection

- Patients received relevant information about their ultrasound scan and the sonographer gave patients many opportunities to ask questions. Language and terminology were adapted to ensure the patient and those with them understood what was happening.

Are services responsive?

Good

We rated it as **Good** because:

- The service made sure there were appointments to meet the needs of patients.
- There was an opportunity to have same day appointments if the scan was urgent.
- Interpretation services were available to patients whose first language was not English.
- The service had made adjustments to be accessible to all.

Are services well-led?

Inadequate

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

- There were no governance processes to enable the manager to monitor the quality of the service.
- The service engaged with patients and staff but there were limited opportunities for them to plan and manage services.
- The manager had a vision for the service but was not making plans to achieve these gaols.
- The clinic lacked a robust approach to quality improvement.

However:

- The service managed patient information well to support all its activities, using secure electronic systems with security safeguards.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Requires improvement	Not rated	Good	Good	Inadequate	Requires improvement
Overall	Requires improvement	N/A	Good	Good	Inadequate	Requires improvement

Requires improvement

Diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Inadequate

Are diagnostic imaging services safe?

Requires improvement

We rated it as **requires improvement.**

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- During the inspection we looked at the training record of the sonographers and saw they had completed a range of mandatory training courses. The registered manager accessed privately available mandatory training. The other sonographer had completed training as part of their employment in an NHS hospital.
- Courses included, but were not limited to equity and diversity, infection prevention and control, information governance, basic life support and privacy and dignity.
- Training was completed in a combination of online and face to face training.

Safeguarding

- **Not all staff knew how to protect patients from abuse. Not all staff had the right training on how to recognise and report abuse or knew how to apply it.**
- The service performed ultrasound scans for patients from the age of 16 years old. One sonographer was trained to level one in adult safeguarding and had not completed any training in children's safeguarding. The second sonographer had received training to level two in both adult and children's safeguarding; however, there was only one sonographer on duty at any time. This did not meet the intercollegiate guidance: Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (January 2014). The guidance states all non-clinical and clinical staff who had any contact with children, young people and/or parents/ carers should be trained to level two.
- There was a flowchart in the policy folder to act as a reminder for staff, of what action to take and who to contact if they identified a safeguarding concern.
- The policy included the different types of abuse including but not limited to physical, sexual and financial abuse. The policy did not include female genital mutilation or PREVENT. PREVENT is a government policy to recognise and support those vulnerable to radicalisation.
- The policy folder included a safeguarding adults at risk policy which stated that it complemented the Sussex Safeguarding Adults at Risk policy and procedure. However, we noted that the policy was dated September 2013. The most recent policy, by Sussex Safeguarding Adults at Risk Policy, was published in May 2019, therefore in the event of a safeguarding concern, staff would not be following up to date guidance putting patients at risk.
- The service did not have a safeguarding policy for children and young people.

Cleanliness, infection control and hygiene

Requires improvement

Diagnostic imaging

- **The service controlled infection risks well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- All areas we visited during our inspection were visibly clean and dust free.
- There was a cleaning schedule for the areas used by the provider. Staff cleaned the equipment they used after each patient. A deep clean was completed once a month by an external cleaner. There was no service level agreement, but the registered manager had verbally agreed this with the cleaner.
- Cleaning logs were completed each day the clinic was in use.
- Staff followed the infection control policy requirement of bare below the elbow. Alcohol-based hand gel was available throughout the clinic and we saw the sonographer using this regularly during the inspection. The sonographer washed their hands in between each patient.
- The abdominal ultrasound probe was cleaned with anti-sporicidal wipes after every use. We observed the sonographer decontaminating the couch and using new couch protection paper in between each patient.
- The service had a policy for the use and decontamination of trans-vaginal scan probes. Prior to transvaginal scans the probe was decontaminated, and a sheath cover placed over the probe.
- The service had domestic taps at the handwashing sink which did not meet the standard required by Health Building Note 00:03 Clinical and clinical support spaces as they were not 'hands free' or lever operated. Taps should be lever or sensor operated as this means they can be easy to turn on and off without contaminating the hands.
- The service did not have hand hygiene audits to monitor staff handwashing technique.

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 based on the ground floor of a shared building. There was a shared waiting room, which was light and airy, with adequate seating available.
- The provider ensured repairs to equipment were carried out if equipment broke down. There was a service level agreement with an external company for the day to day maintenance of equipment. Failures in equipment and medical devices were reported through the technical support team. Staff told us there were usually no problems or delays in getting repairs completed. All equipment conformed to the relevant safety standards and was serviced annually. The last machine service had been carried out in May 2019.
- All portable electrical equipment was service tested yearly. We reviewed records which confirmed equipment including the heater, shredder and printer were serviced in May 2019.
- The service had one ultrasound scanner, in a dedicated clinic room. The scanning room was spacious and could accommodate up to five people including the patient/client. The room had good lighting which when dimmed allowed ultrasound scans to be clearly seen.
- We saw well stocked clinic store cupboards with equipment needed for ultrasound such as contact gel and paper towels. The sonographer told us they had enough equipment and supplies to provide a high standard service.
- In line with similar services the service did not have access to resuscitation equipment, but both sonographers were trained in basic life support. A first aid kit and a body fluid spillage kit were available.
- Waste was handled and disposed of in a way that kept people safe. Waste was separated into clinical and non-clinical waste and stored securely until collection. Records showed the waste was collected by an approved contractor on a weekly basis.
- Fire exits where clearly signposted and could be opened from the inside. However, there were no fire alarms visible in the building. During the inspection

the provider was unable to show us that a fire risk assessment had been completed. Following the inspection, the provider had an external company complete a fire risk assessment. Records showed the building and clinic room were considered safe.

- Fire training formed part of the mandatory training programme. Records showed the fire extinguishers were maintained on a regular basis.

Assessing and responding to patient risk

- **Staff identified and quickly acted upon patients at risk of deterioration.**
- The service had a process to manage patients who suddenly became unwell during their procedure. In the event of a cardiac arrest, staff called 999 for an ambulance. The staff were trained in basic life support and would support the patient until an ambulance arrived. The provider had no incidents of having to call for an ambulance in the last 12 months.
- The sonographer had clear processes to escalate unexpected or significant findings at the examination. The service had established referral pathways for women less than 16 weeks pregnant and those over 16 weeks. Protocols included details for local hospitals
- In the 12 months prior to inspection the sonographers had referred 45 women with unexpected findings to the local NHS providers.
- During the inspection we heard the sonographer advising women to attend their NHS scans as part of their maternity pathway and were clear the private scans were in addition to the antenatal screening provided by the NHS.

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 was led by the registered manager who was a radiographer with a qualification as a sonographer. Their time was shared between clinical practice and non-clinical responsibility.
- One other sonographer was contracted to provide two lists a week for the service. The service employed a receptionist who worked remotely. There were no medical staff employed by the service.
- The service had a lone worker policy. Staff contacted each other at the end of the shift to confirm they had completed the shift safely. The building was occupied by different services which meant the sonographer was never alone.

Records

- **Staff kept detailed records of patients' care. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**
- The service had an up to date general data protection regulation (GDPR) and patient record confidentiality policy. During the inspection we looked at three records which were completed according to the service policy.
- Patients self-referred and booked their scan by telephone. In line with similar services minimal information was recorded at the appointment. This included name, email address, contact details, date of birth, date of last menstrual period and date of positive pregnancy test.
- Electronic records were stored on computer that could only be accessed by authorised persons. The computer was locked when not in use and could only be opened by the fingerprint of an authorised person. No patient information was transferred electronically.
- Records showed that patients were provided with a written report of the results of the ultrasound scan.

Medicines

- This service did not use any medicines.

Incidents

- **The service did not manage patient safety incidents well. Staff did not recognise incidents and near misses and report them appropriately. Managers did not investigate incidents and share lessons learned with the whole team and the wider service.**

Requires improvement

Diagnostic imaging

- The service did not have an incident reporting policy. This meant staff had no guidance as to what an incident was or a process to follow should an incident occur.
- Staff could not describe what would constitute an incident or a never event. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systematic protective barriers, are available at national level, and should have been implemented by all healthcare providers.
- As incidents were not reported there was no opportunity to use learning from incidents to improve the service.

Are diagnostic imaging services effective?

Not sufficient evidence to rate

Evidence-based care and treatment

- **The service did not always provide care and treatment based on national guidance and best practice.**
- Policies, procedures and guidelines were accessible for the sonographer to refer to and available in electronic or paper format. During the inspection we noted some policies were out of date and some policies had no review date.
- We reviewed policies, procedures and guidelines implemented within the service. These were based on guidelines produced by the British Medical Ultrasound Society.

Nutrition and hydration

- The service did not provide food for patients as they were only attending for a short time. Patients had access to water whilst waiting for their scan. Women were advised to attended the scan with a full bladder as needed.

Pain relief

- No formal pain level monitoring was undertaken however, we saw patients being asked if they were comfortable during the scan. None of the procedures undertaken were likely to cause pain to patients.

Patient outcomes

- **Staff made some effort to monitor the effectiveness of care and treatment. They did not use the findings to make improvements or achieve good outcomes for patients.**
- The standard of scan reporting was monitored by the registered manager who was the main sonographer. One scan a month was randomly selected and reviewed using the British Medical Ultrasound Society peer review audit tool patient pathway. This meant the sonographer was auditing their own scans and meant any discrepancies, if identified, could not have a peer discussion at the time of the review.
- The service used the British Medical Ultrasound Society (BMUS) peer review audit tool patient pathway to score the accuracy of the ultrasound scan reports. During the peer review three aspects of the examination were reviewed. The clinical questions, the images and the report and advice given to the patient. Each was categorised into good, acceptable and poor.
- Reviewing one scan a month did not meet the minimum requirement of BMUS that 5% of scans should be reviewed monthly. This meant the provider was not reasonably assured about the quality of the scans provided and could not demonstrate any learning from reviewing the scans.

Competent staff

- **The service did not make sure staff were competent for their roles.**
- Sonographers do not have a protected title and therefore do not need to be registered with the Health and Care Professionals Council. However, both sonographers at the service were also radiographers and had a current registration with the Health and Care Professional Council.
- The manager did not perform any staff appraisals and therefore had no reassurance about the performance of the staff working for the service.

Requires improvement

Diagnostic imaging

Multidisciplinary working

- **Healthcare professionals worked together as a team to benefit patients.** They supported each other to provide good care.
- Sometimes the sonographer would have to give the women bad news about their pregnancy. When this happened, the sonographer would ring their local hospital obstetric department to discuss the findings with the woman's consultant or the midwife in the early pregnancy clinic. This ensured the women had rapid follow up with their NHS team.

Consent and Mental Capacity Act

- **Staff supported patients to make informed decisions about their care and treatment. They did not follow national guidance to gain patients' consent.**
- We saw that the sonographer obtained and recorded verbal consent from patients before undertaking the scan. The sonographer described the importance of gaining consent from the patient before undertaking any procedure. Parents were required to give written consent on behalf of patients aged 16 and 17 at the time of the scan. This is not in line with British Medical Association national guidelines which states all people of the age of 16 are presumed in law to be able to be competent to give consent to medical procedures.
- Patients who needed an internal scan were required to sign a consent form.
- The service had a consent to examination policy. The policy referenced the Mental Capacity Act 2005. The sonographer was up to date with mandatory training on the Mental Capacity Act 2005.
- The sonographer showed an understanding of mental capacity and what actions to take if they had concerns about a patient's capacity. They knew how to support patients experiencing mental health problems and those who lacked capacity to make decisions about their care.

Are diagnostic imaging services caring?

Good

Compassionate care

- **The sonographer cared for patients with compassion.** Feedback from patients confirmed that they had been treated well and with kindness.
- We observed the sonographer interacting positively with patients and those attending the appointment with them. Patients were spoken to with sensitivity and appropriately depending on individual needs. During the inspection we spoke to three patients and seven relatives.
- The manager told us patients receiving bad news about their pregnancy were given as much time as they needed and referred to their NHS antenatal service for ongoing care.
- Patient comments included
  - < >Very kind and nice service. I would definitely go again!",
    "Very detailed ultrasound and explained everything thoroughly. Highly recommended"
- The sonographer was very friendly, professional and put patients at ease. They introduced themselves by name and explained each stage of the procedure during the appointment.
- The sonographer provided the patient with a paper skirt to make sure their dignity was maintained. Patients could undress and dress in private before the scan in the scan room. The scan room door was locked from the inside while intimate scans were being performed.
- Women could request a chaperone while being scanned. This was discussed with the patient when booking in for the scan. Most patients had a relative accompanying them and declined the chaperone. The female receptionist acted as a chaperone when needed, as she lived close by, but had not received training for this role. There had been no requirements for a chaperone in the 12 months before inspection.

Emotional support

Requires improvement

Diagnostic imaging

- **Staff provided emotional support to patients to minimise their distress.**
- The sonographer provided support as required. We saw all patients and those with them being offered reassurance and comfort as required. Patient feedback included comments about the support offered to them during their scan.
- Patients were also given an opportunity to ask questions during the scan and in the consultation after the scan. The sonographer told us that talking to patients during the scan helped to manage their anxiety.

Understanding and involvement of patients and those close to them

- The sonographer involved patients and those close to them in decisions about their care and treatment. Fees were displayed clearly on the website before booking the scan and confirmed in writing by email before the scan appointment.
- Patients and those close the them told us they had received information in a way they understood. Patients were encouraged to contact the service with any concerns.
- Leaflets explaining each scan were available for patients to download from the services website at the time of booking the scan. The sonographer gave a detailed explanation of the scan and allowed time for patients to ask questions before the scan.
- Patients told us they had enough information to understand what was happening during the scan.
- Relatives and friends who accompanied the patient were also encouraged to ask questions about the ultrasound scan if they needed something clarifying.

Are diagnostic imaging services responsive?

Good

Service delivery to meet the needs of local people

- **The service planned and provided services in a way that met the needs of local peopl**e by providing reassurance in early pregnancy and complimenting the NHS antenatal scanning programme.
- Patients could park in a nearby public car park. The service was easily accessible by public transport. A location map of the clinic was provided to patients when booking their scan.

Meeting people's individual needs

- **The service took account of patients' individual needs.**
- The building and room where the scans took place was accessible to wheelchair users.
- Information about any special needs of the woman was recorded within their patient record. For example, information about previous pregnancy loss, being a same sex or transgender couple. This ensured that this information was available during all appointments and the sonographer could make adjustments as needed.
- The sonographer was aware of the individual needs of those living with a disability.
- The scanning couch could accommodate a bariatric patient of up to 200 kilograms.
- A telephone interpretation service was available for patients who did not speak English.

Access and flow

- **People could access the service when they needed it.** Waiting times from referral to scanning patients were in line with good practice. Opening times were flexed to the need of the patient.
- The service matched the service delivery to the needs of their patients. Appointments were made by telephone and could be flexible to meet the needs of the patient. For example, extended appointment times were offered.
- Patients identified as having extra needs would be offered a longer appointment to ensure the woman and those with her did not feel rushed.

Requires improvement

Diagnostic imaging

- On arrival patients were directed to sit in the waiting room, the sonographer would collect the women from the waiting room when ready.

Learning from complaints and concerns

- **The service did not provide information to people on how to give feedback and raise concerns about care they received. The service's policy stated it treated concerns and complaints seriously.**
- Staff told us that they would deal with informal complaints in the first instance, with attempts made to resolve the complaint immediately. The sonographer repeatedly asked patients if they were happy with the service and the ultrasound they had received. All efforts were made to resolve issues before the patient left the clinic.
- In the case of a formal complaint, the service had a policy for handling complaints and concerns. The policy referred patients who were not happy with the service's response to escalate their complaint to the CQC, but we do not have the powers to investigate or resolve individual complaints. We highlighted this to the manager during the inspection.
- The complaints policy provided the sonographer with detailed actions to take if a patient or their relative wished to make a complaint. Complaints were acknowledged within four days and complaints were responded to in 14 working days. The service had received no complaints in the 12 months prior to our inspection.

Are diagnostic imaging services well-led?

Inadequate

Leadership

- **Leaders did not have the skills and abilities to run the service.**
- The registered manager was the lead sonographer. The other sonographer who was employed on a flexible contract had been with the service since 2016. The other employee was a 'virtual' receptionist who worked from home answering the phone and making appointments but lived close enough to come and be a chaperone as needed.
- In the lead up to the inspection the registered manager did not submit a comprehensive provider information request. This meant the inspection team had concerns about the leadership within the service before attending the location for the inspection.
- The manager did not understand the challenges to quality and sustainability and could not identify the actions needed to address them. There was no business plan to ensure the sustainability of the service for the future.
- The manager did not meet with the staff on a regular basis and therefore was not visible. Although the manager described themselves as approachable the inspector was unable to speak to other members of staff to confirm if this was the case.

Vision and strategy

- **The service did not have a vision for what it wanted to achieve, or a strategy to turn it into action.**
- There was no clear vision or a set of values, with quality and sustainability as the top priorities. Staff, people who used the service and external partners has not been asked to collaborate to a set of vision and values.
- The manager had not developed a realistic strategy for delivering good quality sustainable care.
- Although there was no documented vision for the service the manager described a goal of maintaining the quality of the service and doing their very best for each lady who attended the service for an appointment.

Culture

- **The service did not provide opportunities for career development. The service did not have a culture where patients, their families and staff could raise concerns without fear.**

Requires improvement

Diagnostic imaging

- We were unable to speak to other staff who worked for the provider and establish if they felt supported, respected and valued.
- The manager had no meetings with staff so there was no channel to act to address inconsistent behaviour and performance.
- There were no mechanisms to providing staff at every level with the development they need, including high-quality appraisal and career development conversations.
- There was no evidence of a strong emphasis on the safety and well-being of staff.

Governance

- **Leaders did not operate an effective governance process throughout the service. Staff had no regular opportunities to meet, discuss and learn from the performance of the service.**
- 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.
- There was no effective system to review and update policies that were not fit for purpose. The majority of policies had not been reviewed for several years.
- The service did not have regular minuted team meetings but, relied on informal sharing of information as they were a small team, who worked restricted hours. There was no forum to share potential learning from incidents or complaints.
- The service had indemnity and medical liability insurance which covered all staff working within the service in case of a legal claim.

Management of risk, issues and performance

- **Leaders and teams did not manage performance effectively. They identified some risks and issues and identified some actions to reduce their impact, but there was no formalised risk management framework.**
- The registered manager understood some of the risks relating to the premises, service delivery and business. However, at the time of inspection, these risks had not been documented within a risk management framework.
- The standard of scan reporting was monitored by the registered manager who was the main sonographer. The process did not meet the minimum requirement of British Medical Ultrasound Society.
- There were little or no governance and risks monitoring processes for incidents, complaints and patient feedback. This meant the service was unable to identify any trend and themes to monitor & improve the quality of services provided and associated learning.
- The service had a business continuity plan at the time of inspection. This had not been used in the 12 months prior to inspection.

Information management

- **The service managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- The service was aware of the requirements of relevant legislation and regulations to manage personal information. The service had reviewed its systems to ensure the service was operating within General Data Protection Regulations.
- The service managed information securely. The computer used for storing appointments and clinical information related to the scan was protected by a biometric finger print. The computer was locked when not in use so confidential information could only be accessed by those who had the authority to do so.
- The website for the service provided detailed information about the service and the cost. The service had terms and conditions of use, which all women were given when booking the scan.

Engagement

- **The service engaged with patients and staff but there were limited opportunities for them to plan and manage services.**

Requires improvement

Diagnostic imaging

- The service had an easily accessible website and a social media group where patients were able to leave feedback and contact the service. This showed patients were able to engage with the service online and verbally.
- There was no formal mechanism for staff feedback as there were no team meetings or staff survey due to the small size of the service.

Learning, continuous improvement and innovation

- **Learning, continuous improvement and innovation**. **The clinic lacked a robust approach to quality improvement.**
- The service lacked reasonable challenge from internal or external sources regarding quality improvement, governance, safety and effectiveness. There was no focus on quality improvement or innovation.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all sonographers have received the correct level training in relation to safeguarding adults and children.
- The provider must strengthen governance processes to ensure improved assurance around the safety and quality of the service.

Action the provider SHOULD take to improve

- The service should update all policies to reference and reflect up to date legislation, accurate information and national guidance, including the complaints policy and safeguarding policy.
- The provider should consider completing risk assessments for the service's environment.
- The provider should check all risks have been identified and managed, through a formalised process.
- The provider should display clear information in the clinic environment about how to raise a complaint.
- The provider should consider holding and minuting regular meetings with staff to improve governance and strengthen engagement.
- The provider should consider installing clinical standard taps for handwashing.
- The provider should consider undertaking hand hygiene audits to monitor staff handwashing technique.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment

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