

Surrey Ultrasound Services

Quality Report

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

Ratings

Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Not sufficient evidence to rate 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Requires improvement 

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

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

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

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

Surrey Ultrasound Services is operated under Surrey Ultrasound Services Ltd. The service registered with the CQC in 2012. It was last inspected in 2013 under the previous CQC inspection methodology and met all five standards that it was measured against.

We rated this service as good overall. We rated safe, effective, caring and responsive a good and well led as requires improvement.

Our key findings were as follows:

- Staff had undertaken mandatory training specific to their roles. At the time of our inspection it was not clear whether all staff had been trained to a sufficient level of safeguarding children training, however following the inspection, we saw evidence that there was one member of staff who was level 3 trained, and the remaining clinical staff had signed up to complete this training also.
- Practice was evidence based and complied with national guidelines such as the National Institute for Health and Care Excellence.
- Staff were competent to do their role, and had opportunities for additional learning.
- Patient outcomes were followed up and monitored.
- Staff provided care in a compassionate and caring manner.
- Services were planned in a way that met the needs of patients.

However:

- There was no infection control policy or auditing of infection control practice. Staff were not bare below the elbows when scanning, and no hand hygiene or cleaning audits had been undertaken.
- Where risks had been identified, they did not always have an action or timescale for the action to be completed by.
- At the time of our inspection there was no risk register for the service although the service lead was able to articulate what they felt the key risks to the service were. Following the inspection, we were sent a risk register that had been commenced.

Following the inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve.

Amanda Stanford
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Diagnostic imaging

Rating

Good



Summary of each main service

Overall we rated diagnostic imaging as good. This was because there were sufficient staff with the necessary skills and experience to provide the service in line with national guidance. Staff provided care in a compassionate way and feedback from patients was positive and individual needs were recognised and met. Patients could access the service when needed and individual needs were recognised and catered for. However, there were some elements of governance that required formalising.

Summary of findings

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Good 

Surrey Ultrasound Services

Services we looked at:

Diagnostic Imaging Services.

Summary of this inspection

Background to Surrey Ultrasound Services

Surrey Ultrasound Services is operated by Surrey Ultrasound Services Ltd.

The service is an independent healthcare provider that delivered ultrasound scanning clinics under contract for NHS patients. The service primarily serves the communities of Surrey. Their main activity is at their base at the Shadbolt Park House GP Surgery in Surrey, and services are also provided from 14 other GP practices and community hospital locations in the surrounding area. We visited Shadbolt Park House GP Surgery during our inspection.

The service registered with the CQC in 2012. The service had a registered manager in post. The registered manager was also a sonographer and had been in post since the company registered with the CQC.

The service was last inspected in 2013 under the previous CQC inspection methodology and met all five standards that it was measured against.

The service held two, non-obstetric and trans-vaginal contracts with local CCGs on behalf of the NHS. Ultrasound scans were carried out on an appointment basis, with no scans that involved injections, biopsies or drainage procedures performed.

The service treated both adults and children, but the majority of the patients seen by the service were adults.

Our inspection team

The team that inspected the service consisted of two CQC inspectors. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection, South East.

Why we carried out this inspection

We carried out this inspection as part of a comprehensive diagnostic imaging programme. We gathered information about the service to analyse and make judgements on five key questions.

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?
- Is it well led?

How we carried out this inspection

Our unannounced inspection took place on 8 August 2018. Before the inspection, the service provided us with a range of information, which was reviewed by our inspectors and this formed part of the preparation and planning stage of the inspection.

We visited the service's main clinic, located in a GP surgery and spoke with three members of staff including

a service manager, sonographer and administrative staff. Following the inspection we received feedback from a further two members of staff. We spoke with eight patients who gave feedback on their experience of using the service. We looked at eight patient records to support

Summary of this inspection

the information provided. We requested additional documentation in support of information provided where it had not previously been submitted and this was provided.

Information about Surrey Ultrasound Services

Surrey Ultrasound Services has one location, which is their main base in Worcester Park, Surrey. The only service provided is diagnostic imaging. The service is registered to provide the following regulated activity:

- Diagnostic and screening procedures.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's second inspection since registration with the CQC and the first inspection under the new methodology.

Activity (Figures approximate and based on data provided from May and June 2018)

- The service carried out approximately 350 scans per month.

Almost all scans involved adults. Between May and June 2018, less than 2% of patients seen were aged under the age of 18.

Track record in safety:

- The service reported no never events incidents or serious injuries in the last 12 months.
- The service had received and responded to one formal complaint in the previous 12 months.

Six sonographers, three administrators and a medical director worked for the service.






Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Not rated	Good	Good	Requires improvement	Good
Overall	Good	Not rated	Good	Good	Requires improvement	Good

Diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good 

Mandatory training

The service provided mandatory training in key skills to all staff. Training for all staff was completed via an online training resource, which staff told us they found useful and easy to access.

The type of mandatory training was dependent on whether staff held clinical or non-clinical roles. Information governance, fire safety, conflict resolution, equality and diversity and health and safety were modules covered by both types of staff. There was no target completion rate for these modules. However, we saw that the majority of staff had completed these by looking at records.

Additional training had been offered to the administrative team who wished to support with chaperoning patients during their clinical procedures which all members of the administrative team had undertaken.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. There were no safeguarding concerns reported to CQC in the reporting period from August 2017 to August 2018. The service had an up to date “vulnerable adults policy”. This policy defined that staff would contact relevant GPs for a risk assessment to be carried out when they identified a vulnerable adult. It also contained a list of key

contacts such as the local police, relevant local authority and the safeguarding lead for the practice in which the main clinic was based. This was also on display in the administrative office. However, the other 14 site’s safeguarding leads were not listed and this meant that staff at other locations may not have easy access to the designated leads for advice and guidance. Following the inspection, the registered manager advised us that a folder had been created for staff to access all site safeguarding leads contact information.

Staff we spoke with had not made any safeguarding referrals, however they were able to tell us how they would identify a safeguarding issue and what actions they would take. Staff told us that a safeguarding concern was raised by one of their colleagues in the past and this was discussed at their team away day.

The service saw patients from the age of 16 and above, and we observed a 17 year old who came in for a scan during the inspection. The medical director was level three safeguarding trained. However, at the time of our inspection only the service manager was trained to level two in safeguarding children training. According to the Safeguarding children and young people: roles and competencies for health care staff Intercollegiate document, all non-clinical and clinical staff who have any contact with children, young people and or parents and carers require level two safeguarding children training. In addition to this, staff should be able to access a level three trained professional at any time during their work. This meant not all staff had the level of training required to be able to recognise a child who was at risk or know the process for escalating concerns We raised this with the service manager at the time of our inspection.

Diagnostic imaging

Following the inspection, we were provided with confirmation the service lead had also completed level three training following the inspection and we saw the certificate for this. In addition to this, and after discussion with the team, all sonographers had now elected to compete level three training.

At the time of our inspection there was no service specific safeguarding children policy. When the service comes into contact with children (a child is defined as anyone under the age of 18), a safeguarding children policy is required outlining the named professionals and procedures for staff to follow should they need to raise a safeguarding alert or referral. Following our inspection, the service provided us with a Safeguarding Children Policy. This policy contained key information such as the safeguarding leads at each of the sites which the clinics were held from, and wider contacts such as the safeguarding lead at the local clinical commissioning group.

The service manager told us that they had undertaken additional learning of self-harm models as part of the clinics that the service ran within the local prison. Within the prison setting there were specific escalation pathways that were in place to raise concerns.

An important part of safeguarding children training is the identification and escalation of female genital mutilation (FGM). The service manager was able to describe FGM and the implications of identifying this procedure and the actions she would take.

Cleanliness, infection control and hygiene

The service controlled infection risks. However, there were no policies and procedures to ensure the risk of infection and prevention was managed effectively.

There was no service infection control policy. Infection control policies are documents that staff can refer to ensure they manage the risk of infection whilst at work. Following the inspection the service provided us with a hand-washing policy for the service which detailed effective hand washing techniques. However the policy did not address other infection control issues such as uniform use (for example being bare below the elbows) or cleaning of the room and or equipment after each use. There was also no procedure for dealing with patients who may have a contagious illness.

Staff had access to an ample supply of personal protective equipment (PPE). We saw staff using PPE appropriately when interacting with patients and we observed staff washing their hands in between patient contacts in line with the World Health Organisation (WHO) 'Five moments for hand hygiene'. However, we saw that the sonographer was not bare below the elbows when scanning patients which was not in line with best practice. Clinical staff should be bare below the elbows to help prevent the spread of infection. We fed this back to the service manager who told us they would review this.

We saw alcohol based hand cleansing gel was available for patients and staff to clean their hands both at the clinic entrance and within the treatment room. Within the treatment room a hand washing sink was available to ensure that hands could be washed before and after patient contact, which we saw staff using.

No hand hygiene audits had been undertaken by the service. Hand hygiene audits are where trained members of staff observe staff and patient interactions to ensure all best practice with hand hygiene is followed. While we observed good hand hygiene during our inspection, audits provide additional assurances that good practice is consistently upheld throughout the service.

We observed clinical waste was handled, stored, and removed in line with national guidance, HTM 07-01, Control of Substances Hazardous to Health and the Health and Safety at work regulations. This meant that waste was disposed of and managed in a safe way.

In the last 12 months prior to our inspection, there were no incidences of healthcare acquired infections. We spoke to the service manager regarding how Medicines and Healthcare products Regulatory Agency (MHRA) safety and equipment alerts were received and acted upon. They were able to describe a relevant alert (MDA/2012/038) regarding reusable transoesophageal echocardiography, trans-vaginal and trans-rectal ultrasound probes (transducers) and failure to appropriately decontaminate.

We observed that the ultrasound probe was cleaned in front of the patient and if necessary, a latex-free sheath was placed over the probe. At the end of each procedure the couch was prepared for the next patient with clean paper. We observed the sonographer wash their hands and clean the probes.

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The cleaning of the rooms was the responsibility of the GP surgery. Staff told us that there were rarely any problems found with the cleanliness of the rooms they used, but if there was they would raise this with the practice manager. The ultrasound environment we visited was visibly clean.

Equipment and environment

The service had suitable equipment and maintained them appropriately.

Staff told us that the ultrasound machines were serviced annually and maintained by a recognised service team. We saw service records for three ultrasound machines which were serviced in April 2018. In addition to this, where faults arose, staff called out engineers to assess and perform repairs. We observed a fault repair form for one of the transducers following a damaged membrane which occurred.

Equipment such as ultrasound machines and probes were on a rota for replacement to ensure that they remained current and in good working order.

The environment in which the scans were performed was small and cramped but well arranged by the service. The room was darkened to ensure scans could be observed clearly and there were blinds on the windows to ensure patient privacy. We saw on the location risk assessment checklist that the size of the room was small and posed a problem for access to wheelchair users. However, there were no actions or agreed timescales documented for this identified risk. We spoke to the service manager who told us that wheelchairs do fit in the room, however it becomes cramped.

The couch used in the treatment room had a visible tear in the surface which meant that it could not be cleaned effectively. We saw an email trail showing that the service manager had escalated this to the practice manager for replacement but there was no estimated timescale for this to be completed. The couch was covered with fresh paper towel for each patient, to help minimise the spread of infection.

The waiting room for the service was the GP surgery main waiting room which was light and airy, with adequate seating available. A patient toilet was accessible close to the room used for scanning

We saw that all disposable gloves used were latex free, which ensured that staff or patients with a latex allergy were protected. We observed fire notices on the room door indicating the nearest exit and protocol for evacuation.

Assessing and responding to patient risk

The service had arrangements to manage risks to patients.

The service accepted patients who were physically well and could transfer themselves to a couch without support. The lack of a hoist in the clinics meant that patients who were not able to transfer themselves would be re-referred to an appropriate centre that could cater for less mobile patients.

We spoke to staff who told us that they very rarely got referrals missing key information such as date of birth or clinical history, however when this occurred, administrative staff would contact the referrer and ask for further information prior to booking the patient appointment.

Scan reports were completed immediately after the scan had taken place, which we observed during our inspection. If there were any abnormalities detected, the sonographer faxed results to the relevant surgery, or would call the relevant referrer to inform them of the results. They would then also make an urgent appointment for the patient prior to them leaving the consultation. If no appointment was available, she would ensure the ultrasound report was reviewed by the duty GP and contact was made with the patient.

The service had a patient emergency handling flowchart which were guidelines of how to respond to a patient that required urgent medical attention. This detailed what the administration team, nurses and doctors should do if there was an emergency during a consultation. This was different depending on each type of staff member, for example, administration team were advised to call either the duty doctor or to press the emergency buzzer, whereas the clinical team were advised to treat or use emergency buzzer. Staff also told us that the medical director was available to provide advice over the telephone. The computer system had an emergency call

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system which meant staff could alert the GP staff there was an emergency should one occur. The clinics that ran from GP surgeries could also access the on call GP in event of emergencies.

Referral forms contained clear guidance regarding the use of trans-vaginal scans and the types of patients that could be referred for these scans. Due to the invasive nature of these scans, women who were virgins could not be referred for these scans. Staff told us that if on arrival there was any doubts or concerns regarding the appropriateness of a trans-vaginal scan, they would offer a non-invasive abdominal scan instead.

Clinical members of staff had basic life support (BLS) training and records showed five out of six staff members had completed this. BLS training gives staff a basic overview of how to deal with a patient who may have stopped breathing, such as starting cardiopulmonary resuscitation.

The service kept risk assessment checklists for each of the locations it worked from. This was a tool to identify any potential risks within the service locations and to note actions and timescales. An example of this was the weight limits of the couches within each of the locations to ensure that patients exceeding this limit do not use the couches. However, on one of the location checklists (Linden House) the weight limit was not known with an action to check, but this had not been completed and there were not agreed timescales for completion.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to provide the right care and treatment. There were two full-time and three part-time sonographers, one of whom was the service manager. There was also one full time administrative member of staff and two part-time administrative staff. There were no current sonographer or administrative vacancies, however the service manager told us that should a suitable candidate approach the service, they would consider taking on additional staff. The service did not use agency or bank staff.

Data provided to us prior to the inspection demonstrated that in the three months before the inspection, there had been no sonographer sickness episodes, and 13.7% sickness episodes for administrative staff. Sickness in the

organisations was covered by other sonographers within the team. Clinics were only set up where there were two sonographers available to cover each site and clinics were rarely cancelled.

The majority of staff at the service had been with the company since its creation, and they told us that staff turnover was low. In the last 12 months, two members of staff had left but this was due to change in personal circumstances as opposed to dissatisfaction with the company.

Medical staffing

The medical director of the service was a registered GP, however they did not have any direct contact with the patients routinely. There were no other doctors employed by the service.

Records

Patient records were managed in a way that kept patients safe and staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment.

The service used an electronic patient information system. Access to this was password protected and therefore records were kept confidential and stored safely. Service staff had access to the GP practice computers via a dedicated smart card that enabled secure access to the computers. Staff also had secure NHS.net emails to enable secure email to and from GPs and referrers. We reviewed eight sets of patient records, all of which were complete, legible and up to date. We observed the sonographer checked the electronic systems for previous scan details and clinical history before starting procedures.

Medicines

The service did not use any controlled drugs or medicines.

Incidents

The service managed patient safety incidents and had relevant policies. As the service did not report any incidents, it was difficult to assess any learning as a result of incidents. We saw on the yearly away day minutes that significant events was a standing agenda item. However as none had been reported, there was no discussion around this

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Surrey Ultrasound Services did not report any never events in the 12 months prior to our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

In accordance with the Serious Incident Framework 2015, the service did not report any serious incidents in the 12 months prior our inspection.

All minor non-preventable accidents were reported in the practice accident log book which we saw during our inspection. No accidents had been reported in the book for the last 12 months.

The service had a Significant Event Reporting Policy. This policy described the process for reporting incidents using a paper form. The policy stated that these would be recorded in the significant events log and reviewed every six months to ensure all actions had been followed up. Staff told us that they had no incidents over the last 12 months. When an incident occurred, staff reported this on the service system and also on the GP practice's incident reporting system. All reports were reviewed by the service manager. Any major concerns were escalated to the medical director who was the head of governance for the organisation.

Staff gave an example of learning from a complaint where a procedure was unable to go ahead as scheduled. The problem had arisen from details not being fully recorded on the referral form. When the patient arrived, staff identified that they would not be able to perform the procedure due to the weight limit on the couch and therefore had to re-refer the patient to a site that could accommodate them. As a result of this, staff checked the weight limits on the couches at all of the sites clinics were run from, and told us they were in discussions regarding the use of bariatric equipment at some of the clinic locations.

During the inspection the service was made aware that an incorrect patient had been mailed an appointment letter due to a mistake on the referral form. The patient was advised to destroy the letter and the administration team contacted the referrer and requested the correct

address information. This was not reported as an incident which meant staff may not always recognise reportable incidents and the service may not be able to effectively monitor incident themes and trends.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate 

Evidence based care and treatment

Care and treatment was delivered in line with current legislation and nationally recognised evidence-based guidance. The service had written locally agreed examination protocols for each examination. Evidence based clinical protocols were developed in line with best practice guidance. For example, the gynaecological scan protocol reference National Institute for Health and Care Excellence (NICE) quality standard (QS) 18 for ovarian cancer – this stated that patients with raised cancer markers should have an ultrasound scan performed within two weeks.

The service had protocols for each type of scan carried out. These protocols included clinical findings that should trigger an urgent or two week wait (suspected cancer) referral. We saw a compliment from a referring doctor praising one of the sonographers for their quick response upon finding abnormalities on a scan. Acting on the findings of the sonographer, it was discovered that a patient had an aggressive cancer that could be treated as a result of the scan findings.

The medical director was responsible for checking and updating NICE guidance that was relevant to the service. All sonographers were given a data USB stick that included all the services' protocols and guidelines so that these could be accessed at anytime.

Nutrition and hydration

For certain types of scans, such as abdominal scans, patients were required to have a full bladder to enable clearer imaging. Advice to drink at least two pints of liquid prior to the examination was included as part of the information patients received on their clinic letter.

Patient outcomes

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We saw feedback from a GP to a sonographer stating that the: “reporting I receive from the service manager is always of a very high standard. Reports always take into consideration the clinical history and that makes them very useful for ongoing management”. At the end of each procedure, we observed the sonographer summarising what the scan showed for the patient. Patients at this stage were also provided with follow up advice for example: GP appointment for follow up, re-scan in line with best practices guidelines, or no follow up necessary. The service completed a number of audits. We saw an audit in progress that compared the ultrasound scan findings by the service with the outcome of the patient further down the pathway. We saw out of the seven scans reviewed as part of the audit, all seven patients had been followed up and had confirmed findings reported.

Competent staff

Sonographers do not have a protected title and are therefore not required to be registered with the Health Care Professions Council (HCPC). However; radiographers that have an extended scope in sonography are required to be registered with the HCPC. We saw that all the sonographers in the service had a current registration on the HCPC website. This meant that these staff members had met the standards required to ensure delivery of safe and effective services to patients.

Staff told us that new members of staff had a four-week induction period. We saw that as part of this, new staff had to sign an induction sheet to say they had been made aware of pertinent policies such as data protection and fire procedures.

The medical director was responsible for conducting all staff appraisals. Data provided to us prior to the inspection showed that both administrative and clinical staff had all received an appraisal within the last 12 months. However, during the inspection, we only saw appraisal documentation for the previous year (April 2017). Following the inspection the service manager advised us that this was due to annual leave and that all staff had been made aware of the delay to their annual appraisal being undertaken. We saw blank ‘preparation for appraisal’ templates which were for staff to use to focus their thoughts ahead of their appraisal and staff told us they felt their appraisals were meaningful.

Staff were supported if they wanted to go on additional training courses.

Clinical staff held sporadic interesting and rare scan meetings to share best practice amongst the team.

The administrative staff working within the service had the opportunity to observe the different types of scans to enable them to have an understanding of what the different procedures involved. This enabled them to have an understanding of the patient journey and to be able to provide accurate information to patients that called pre-procedure.

Multidisciplinary working

Staff of different kinds and from different providers worked together as a team to benefit patients.

Staff from the service worked closely with GPs from the practices where they ran their clinics. Staff reported good working relationships with the practices and that they felt part of the team. Examples were given where service staff were invited to the GP practice learning lunches.

The service ran a GP satisfaction survey which was sent to all GPs who had referred patients to the service. The latest survey was carried out during November 2017 and 52 responses were received. The data did not specify response rate. In response to the question “Are you satisfied with the service provided by SUS?”, the majority (98%) responded that they were very satisfied.

The service used an electronic patient information system. This programme promoted multidisciplinary (MDT) use of records. This meant they were accessible by many health care professionals and ensured the health care record for the patient followed a smooth transition through the care pathway and allowed for good care planning and delivery of care. There was a secure image exchange portal in operation. This meant that clinical imaging could be shared between a range of healthcare professionals.

Seven day service

As the service was not an acute service, it did not operate seven days a week. Instead it operated Monday to Friday across a range of clinic locations and times.

Consent, mental capacity act, deprivation of liberty safeguards

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There were processes to ensure patients consented to procedures. Patient's verbal consent was sought on the day of the procedure and we observed this occurring. Patients were provided with information prior to their appointments and were given opportunities to ask questions when they arrived. This ensured the verbal consent given was informed.

The sonographer was aware of 'Gillick' competencies for patients under the age of 18. To be Gillick competent, a young person (aged 16 or 17) can consent to their own treatments if they are believed to have enough intelligence, competence and understanding to fully appreciate what is involved in their procedure.

Mental Capacity Act training was available for staff. However only three members of staff had completed this training at the time of our inspection. This meant that not all staff may have known their responsibilities around assessing mental capacity.

Are outpatients and diagnostic imaging services caring?

Good 

Compassionate Care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

The service ran a yearly patient survey and we saw the results from the 2017 survey. The survey was carried out over one month of the year, and surveyed 128 patients at nine different clinic locations. There was a response rate of 100% and 91% of patients said they would recommend the service, with 9% leaving the answer blank. No patients answered the question with a 'no' response. To the question "what was your overall opinion of the service, 98% of patients answered "very good".

From July 2017 to June 2018 the service received four written compliments. We reviewed the compliments folder and saw that comments from patients included: "Efficient and polite manner, service I received was

superb" and "thank you for making my visit as comfortable and as relaxed as possible". Staff told us that these compliments were stored and shared with staff on their team away days.

We observed the administration team responding to calls with a caring and compassionate manner. Patients that were anxious about appointments were given advice and information and staff took time to put them at ease. We observed eight patient consultations and spoke to the patients following their procedure. The comments we received were all positive including: "(the sonographer) was lovely and very professional", "she really put me at ease, I was a little nervous", "she was brilliant".

We observed that the sonographer had a very friendly but professional manner with patients and she instantly put patients at ease. Three of the patients we spoke to told us how the sonographer had made them feel comfortable.

The sonographer provided all patients with a 'paper skirt' to ensure their dignity was protected at all times. She also provided additional paper for patient's upper body when required to ensure their clothes was protected from the jelly used for the procedure.

It was not possible for a dedicated changing area to be made available for patients due to the size of the room. This was documented on the risk assessment checklist, with a query over whether a disposable curtain could be utilised, but no action or timescale was aligned with assigned to this. We observed that in practice however, staff did all they could to ensure patient's privacy was respected, moving to the door whilst patients were getting changed and the door was locked for each patient to ensure the room remained private during consultations. The scan room was 'L shaped' with a couch in the corner. Whilst there was no curtain around the couch, there was an area where the sonographer could stand which meant the patient's dignity was protected when they undressed.

We observed that patients were asked if they would like a chaperone during the procedure. There was also a poster on the wall offering this service. Prior to the inspection, if a chaperone was required one of the GP practice staff would be used for this purpose, but the service manager recognised that the administration team with appropriate training could fulfil this role, and the team have since

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then had their chaperone training. They were waiting for confirmation of their DBS certificates to come through prior to any chaperoning tasks. This was in line with the service's chaperone policy.

Emotional Support

We observed administrative staff talking to patients on the telephone who had questions about their scans. They were able to reassure the patients, give advice about what to expect during the appointment and were reassured that they could stop at any time if they found the procedure uncomfortable.

Patients were also given an opportunity and encouraged to ask questions during the procedure and the sonographer told us that talking the patients through the procedures helped to manage their anxiety

Understanding and involvement of patients and those close to them

We saw that patients were provided with information before and during their appointment which helped them understand what was happening. Patients told us they appreciated this and felt there was enough detail to help them understand what was happening during the procedure: "the appointment letter gave me all the information I needed", "I got good consistent information" and "she (the sonographer) answered all my questions in a very understandable way".

As part of the 2017 patient survey, patients were asked "how well was the examination explained to you?" with 93% of patients responding very good, with the remaining 7% asking 'well' or 'average'.

Patients were able to make their own decisions about their care- for example, where an internal scan was requested for females, an alternative less invasive scan could be offered and this was detailed in the appointment letter.

The patients had an explanation about the jelly used during the scan which was warmed prior to use for patient comfort. The sonographer shared the screen with the patients during the scan and talked the patients through what they were looking at.

At the end of each procedure each patient was given very clear instructions about what aftercare they required, for example for GP follow up, or for re-scan in line

with guidelines. In the 2017 patient survey that the service ran, 99% of patients answered 'yes' to the question "were you told when your referring doctor would receive the ultrasound result and the next steps for you?"

At the end of each procedure, we observed the sonographer summarising what the scan showed for the patient. Patients at this stage were also provided with follow up advice for example: GP appointment for follow up, re-scan in line with best practices guidelines, or no follow up necessary.

Are outpatients and 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 people.

The service operated under contracts from local Clinical Commissioning Groups (CCGs) and worked within GP practice buildings. They were therefore regularly in contact with external stakeholders which provided an opportunity to assess the needs of local people.

The provider matched the service delivery to the needs of the people. An example of this included decreasing the number of clinics over the summer months after noticing a reduction in referrals over the same period the previous year. However, this year, the expected reduction did not occur and the service had to reinstate additional lists to meet the expected increase in demand.

Staff told us that patients appreciated the accessibility of the service. Clinics were based in GP practices with accessible car parks and this allowed patients to attend in a less intimidating environment than that of a hospital or acute site.

Meeting people's individual needs

The service took account of patients' individual needs. At the previous inspection of the service, staff told us that they were rarely made aware of any patient's special

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needs. During this inspection, we saw that on the referral form a box had been included for referrers to indicate whether the patient had any physical or communication issues.

The surgery was accessible to wheelchair users. The scanning room was small, but if some chairs were removed it would be accessible to wheelchairs. Staff could access telephone interpreting where needed and they utilised the GP interpreting service for this. The service sometimes used friends or family to translate although this was avoided where possible.

The couches used for patients to lie on when having their scans could not accommodate bariatric patients and there was no hoist available for immobile or non-weight bearing patients and therefore these patients could not be referred to the service. However, staff told us that some of the other locations provided adequate facilities so patients could be transferred to other sites if that was more appropriate.

Some of the administration staff we spoke with had completed dementia training. Staff gave examples of how the needs of patients with learning difficulties or other individual needs were met by the service. A patient who had a problem with crowds/people was cited. This patient needed a scan, so the sonographer came in early before the surgery opened to do the scan, to manage their anxiety and ensure they had their diagnostic investigation. It meant the patient had the waiting room to themselves, and had their procedures completed before other patients arrived.

The site had on street parking available outside the surgery, and there were wheelchair spaces available at the front of the surgery.

Access and flow

People could access the service when they needed it.

Most referrals that came to the service were from GPs. These came to the administration team based at the main office in Shadbolt House Park Surgery and were sent via email or fax. There was a standard referral form that included all necessary details including patient demographics, allergies, previous medical history and clinical indications for the scan. There was also a clear section to indicate if the procedure was routine, urgent or

needed to be done 'soon'. Routine appointments were booked within four weeks, 'soon' appointments were booked within three weeks, and urgent appointments booked within two weeks.

Staff told us that when there was a surge in referrals, extra clinics could be arranged with the service manager covering additional lists. Upon receipt of the referral, the administration team scheduled an appointment and sent a letter to the patient which was individual to the type of scan being requested. All letters had a brief description of what an ultrasound scan was, and a more detailed explanation of the exact type of scan they were due to have was included beneath this.

The appointment letter included a map to ensure the patient could find their way to their appointment as well as contact number for patients to call if they required additional information or had to change their appointment. Upon arrival to the surgery, patients checked in at the front desk and took a seat in the waiting room until called to the room by the sonographer. The sonographer then reviewed the referral form, and talked to the patient about their understanding of why they were referred and were encouraged to give a history of their symptoms.

To help reduce 'did not attend' (DNAs) figures, the service had set up a text reminder service for patients. The text message reminded patients of the date and time of their appointment, along with the name of the sonographer that was due to scan them at their appointment. Staff told us that since the introduction of the text reminder service the number of DNAs had reduced, however they did not have data to demonstrate this.

The service kept a cancellation list for patients that requested for their appointment to be moved forwards. There was a process in place for referring patients back to their GPs who did not attend. This meant that where possible, patients could be seen quicker in the event of another patient cancelling.

During our inspection we did not observe any long waits or delays for patients. In the annual patient survey, out of 128 patients surveyed, 96% of them indicated that they were called to their appointment within 30 minutes of arriving. Patients we spoke to during the inspection told us that they: "didn't have to wait long for an appointment" and "I was called in very quickly".

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Learning from complaints

There were processes to ensure patients and their relatives could make a complaint or raise concerns and were aware of how they could do this.

One patient had raised a formal complaint about the service in the last 12 months. Staff told us that when a patient has a concern they always tried to talk to the patient first to apologise and resolve any issues where possible. If the concern was not resolved in this manner, patients could write to the service lead. Patients were encouraged to send written complaints to the service manager, who sent an acknowledgement within three working days and an estimated timescale for a full response letter.

Are outpatients and diagnostic imaging services well-led?

Requires improvement 

Leadership

Leaders were visible, approachable and prioritised sustainable and compassionate care.

The service manager was committed and passionate about patient care and a high-quality service. They understood the challenges the service faced, in particular the national shortage of sonographers and the impact this could have on the service in the future.

Staff told us they felt supported by the management team and that they were friendly and approachable. Staff felt confident in approaching them regarding issues to do with their professional or personal life.

Culture

The service manager promoted a positive culture that supported and valued staff. We spoke to three members of staff during our inspection, and following the inspection, two further members of staff contacted us to tell us about their experience working for the service. All of these staff members spoke positively about the culture of the service.

Staff told us that members of staff who had commitments outside of work were supported where possible with flexible working arrangements and this supported a good work/life balance.

During the inspection we informed the service manager that there were areas of the service that required improvement. They responded positively to this feedback and immediately put actions in place to make improvements, demonstrating an open culture of improvement.

Governance

The service had a clear organisational structure with a medical director, service manager and five sonographers.

The service manager reported to the medical director for the service. The service manager was responsible for investigating incidents and responding to complaints, in conjunction with the medical director who was the governance lead. However, there were no incidents reported by the service within the last 12 months. This meant it was not possible to accurately assess how learning from incidents was embedded. However we did see that the away day minutes had a standing agenda item for significant events. In addition to this, we did see that as a result of a complaint, actions were taken to reduce the risk of the event that led to the complaint re-occurring.

Managing risk, issues and performance

The service had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The service did not have a risk register in place at the time of our inspection although the service manager was able to describe when asked, the types of risk that the service was facing.

Following the inspection, we were sent a risk register that had been commenced that contained eight risks. The highest rated risk for the service was listed as the national shortage of sonographers and the mitigation in place was to reduce the number of sub contracts should the service themselves become short of sonographers and unable to replace.

The service told us that patients were always booked within the agreed timeframe with the CCG (for example for routine patients within four weeks). However there was not a sufficient level of data available to support this.

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We saw data that showed when a patient had been added to the list and when they were seen in clinic, however as the data did not include the urgency of referral codes (such as routine, urgent or soon), it was not possible to breakdown whether patients referred on the three different levels of urgency were seen within their individual target windows.

Managing Information

The service managed and used information to support its activities, using secure electronic systems with security safeguards.

Information governance training formed part of the mandatory training programme for the service, and staff we spoke with understood their responsibilities regarding information management. Computer screens were locked when staff were not sitting at their desks to prevent information breaches.

We saw that general data on the demographic of the patients seen had been collected from May to June 2018. This included information such as the source of referral and whether a patient had attended their appointment. This was sent to the CCG to be able to monitor the amount of referrals and examinations that the service were performing.

Engagement

The service engaged with patients, staff, the public and local organisations to plan and manage appropriate services.

The service ran an annual patient survey for patients to give their feedback about their experience. We saw from the latest survey that the results were overwhelmingly positive.

The service ran an annual GP satisfaction survey so that referrers had the opportunity to feedback about their experience of the service.

The service had a website for members of the public to use. This held information regarding the types of scans offered and what preparation was required for each type. There was also a feedback form that patients could complete regarding their experience and contact details for the service.

As not all staff worked from the same site, they told us that mobile messaging groups had been set up so that the team could keep in contact throughout the day. Staff told us that patient identifiable information was not shared on these groups. Staff we spoke with told us that this worked well and made them feel connected. Emails were also commonly used.

In addition to this daily contact, there were annual away days that the whole team attended and staff told us how valued these were. We saw minutes from these which included standard agenda items such as site issues, office issues, audit and significant events or complaints. In addition to this, the clinical staff held sporadic interesting and rare scan meetings to share practice amongst the team.

Learning, continuous improvement and innovation

All staff that worked for the service had the opportunity to be share holders in the company.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

The provider must ensure there are processes and procedures in place to adhere to and monitor infection prevention and control. Policies and audits should reflect best practice and be in accordance with Health and Social Care Act (2008); code of practice on the prevention and control of infections and related guidance.

Action the provider **SHOULD** take to improve

The service should ensure that all staff complete mental capacity act training.

The service should ensure they monitor the performance of the service against the three pathway key performance indicators.

The service should ensure that where risks are identified, appropriate actions and timescales for completion are included.

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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>The provider must ensure there are processes and procedures in place to adhere to and monitor infection prevention and control.</p> <p>Policies and audits should reflect best practice and be in accordance with Health and Social Care Act (2008); code of practice on the prevention and control of infections and related guidance.</p>