Ultrasound Diagnostic Services

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?	**Requires improvement**

Overall summary

Ultrasound Diagnostic Services is operated by Ultrasound Diagnostic Services. The service was established in 1977 and has been managed by Ultrasound Diagnostic Services since 2012. The service offers diagnostic tests for adults and young people.

Patients are offered ultrasound scans for obstetrics and gynaecology. This included scans at various stages during pregnancy, fetal echocardiography, lower abdominal and pelvic scans and ovarian cancer screening. The service had three diagnostic imaging rooms and a reception area in the basement.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 27 November 2018.

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.

Services we rate

We rated it as requires improvement overall.

- The service had a strong, visible person-centred culture. Staff were highly motivated and aspired to offer care that was kind and promoted people's dignity.
- Patient's individual needs and preferences were central to the planning and delivery of the service. The services were flexible and provided choice.
- The service had systems to monitor the quality and safety of the service. The use of audits and recording of information related to the service performance was to a good standard.
- The centre was clean and tidy with infection control processes in place. There were no reported infections in the last 12 months.
- Staff were positive about their working experience and felt supported to be part of a team.
- Patients spoken with and feedback we received about the service was positive. There was a 24-hour turnaround for patients from their initial contact to having their scan done at the centre.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- Staff demonstrated kindness and understanding of how to meet patients' needs to ensure that their experience was positive.
- There was an effective maintenance schedule for all equipment.
- There was effective multidisciplinary team working between the service's staff and other staff at different provider locations.
- Patients had the choice of booking the dates and times of their diagnostic imaging appointments to suits their needs.

We found areas of practice that require improvement:

- The service did not have an effective risk management system for monitoring and mitigating the various risks arising from the undertaking of the regulated activities.
- The service did not have a designated safeguarding lead trained to level three in safeguarding children.
- Not all sonographers within the service had professional indemnity insurance. Independent sonographers are required to have suitable professional indemnity in place so they are protected if a medical negligence claim is made against them.
- The service did not ensure that policies and procedures are reviewed regularly.
- The service had not completed infection control and hand hygiene audits.
- The service did not have an effective system for reviewing incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.
- The service did not maintain accurate, complete and detailed records for staff, such as references and evidence of immunisation against Hepatitis B.

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

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and the South Eas

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	**Requires improvement** 	We rated the service as requires improvement The service did not have an effective risk management system for monitoring and mitigating the various risks arising from the undertaking of the regulated activities. The service did not have a designated safeguarding lead trained to level three in safeguarding children. Not all sonographers within the service had professional indemnity insurance. Independent sonographers are required to have suitable professional indemnity in place so they are protected if a medical negligence claim is made against them. The service did not ensure that policies and procedures are reviewed regularly. The service did not have an effective system for reviewing incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result. The service did not maintain accurate, complete and detailed records for staff, such as references and evidence of immunisation against Hepatitis B.

Summary of findings

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Requires improvement

Ultrasound Diagnostic Services

Services we looked at:
Diagnostic Imaging

Summary of this inspection

Background to Ultrasound Diagnostic Services

Ultrasound Diagnostic Services is operated by Ultrasound Diagnostic Services. The service was established in 1977 and has been managed by Ultrasound Diagnostic Services since 2012. The service offers diagnostic tests for adults and young people. The centre primarily serves the communities of greater London. It also accepts patient referrals from outside this area.

Ultrasound Diagnostic Service was registered with the CQC on 16 March 2012.

The centre has a registered manager in post since 2012.

Our inspection team

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

Information about Ultrasound Diagnostic Services

Ultrasound Diagnostic Services is operated by Ultrasound Diagnostic Services. The service was established in 1977 and has been managed by Ultrasound Diagnostic Services since 2012. The service offers diagnostic tests for adults and young people.

Patients are offered ultrasound scans for obstetrics and gynaecology. This included scans at various stages during pregnancy, fetal echocardiography, lower abdominal and pelvic scans and ovarian cancer screening.

The service is registered to provide the following regulated activities:

- Diagnostic and screening procedures

The service had three diagnostic imaging rooms and a reception area in the basement. Each diagnostic imaging room had an ultrasound machine.

During the inspection, we spoke with five staff including; medical staff, reception staff and the practice manager. We spoke with two patients. During our inspection, we reviewed six sets of patient records.

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

Activity (November 2017 to October 2018)

- In the reporting period November 2017 to October 2018 there were 4,347 diagnostic imaging tests.

Three fetal medicine consultants, six sonographers, four administrators and a practice manager worked at the service.

Track record on safety

- No Never events
- No clinical incident
- One incident
- No complaints

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 safe as requires improvement because:

- The service did not have a designated safeguarding lead trained to level three in safeguarding children. The safeguarding policy needed to be updated to include revelant contact details.
- The service did not have a business continuity plan so that staff would know how to respond in the event of a major incident.
- The service had not completed infection control and hand hygiene audits.
- The service had not risk assessed the emergency medicines and equipment to ensure it was in line with guidance issued by the Resuscitation Council.
- The service did not have an effective system for reviewing incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.

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

- There were systems and process for reporting and investigation of safety incidents that were well understood by staff.
- There were effective systems to ensure patient safety. All staff knew their roles and responsibilities in ensuring patients and their relatives were safe.
- Staff understood the duty of candour.
- There was an effective maintenance schedule for all equipment.
- The centre was visibly clean, tidy and clutter free and there were arrangements for infection prevention and control.
- Patient records were secured and stored appropriately.
- Staffing levels were maintained by management to ensure patient safety.
- Staff were competent and the service provided mandatory training.

Are services effective?

We do no rate effective, however we found;

- The service had policies and procedures which were developed in line with national guidance and staff knew how to access them.
- Staff understood their roles and responsibilities in obtaining consent

Summary of this inspection

- The centre encourage staff to participate in training and development to enable them to develop their clinical skills and knowledge.
- Staff had completed their appraisals.
- The practice manager was the dedicated lead for professional development who managed the processes for ensuring all staff had received training and competency assessments applicable to their roles
- There was effective multidisciplinary team working between the service's staff and other staff at different provider locations.
- Staff had access to all the information they needed to deliver care and treatment to patients in an effective and timely manner.

Are services caring?

Good

We rated caring as good because:

- People's emotional and social needs were highly valued by staff and are embedded in their care and treatment.
- Staff understood and respected patients cultural and religious needs.
- The service had a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity.
- Staff understood the impact that patients care, treatment and condition had on their wellbeing.
- Patients felt fully informed about their care and treatment. The patients we spoke with had a good understanding of their condition and the proposed diagnostic test they attended for.
- All patients we spoke with, consistently gave positive accounts of their experience with the centre and its staff. They told us the staff were excellent and that they were always polite and courteous.

Are services responsive?

Good

Are services responsive?

We rated responsive as good because:

- Patient's individual needs and preferences were central to the planning and delivery of the service. The services were flexible and provided choice.
- The centre did not have a waiting list. Staff told us patients could receive an appointment within 24 hours.
- There were effective arrangements in place for planning and booking of diagnostic imaging appointments.

Summary of this inspection

- Patients had the choice of booking the dates and times of their diagnostic imaging appointments to suits their needs.
- There was a system for capturing and investigating complaints.

However, we also found the following issue that the service provider needs to improve:

- The service did not have a procedure for treating patients with a learning disability, dementia or bariatric patients. The service had not considered the needs of these patient groups

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The service did not have an effective risk management system for monitoring and mitigating the various risks arising from the undertaking of the regulated activities.
- Not all sonographers within the service had professional indemnity insurance. Independent sonographers are required to have suitable professional indemnity in place so they are protected if a medical negligence claim is made against them.
- The service did not ensure that policies and procedures are reviewed regularly.
- The service had not completed infection control and hand hygiene audits.
- The service did not maintain accurate, complete and detailed records for staff, such as references and evidence of immunisation against Hepatitis B.
- The service did not have an effective system such as staff meetings to share learning and practice with staff.
- The service did not monitor performance by collecting and analysing data and using the results to improve patients experience.

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

- There was strong leadership of the service, and staff spoke positively about the culture of the organisation.
- During our inspection, it was clear that the quality of patient care and treatment was a high priority.
- There was a clear governance structure and reporting framework that provided timely information to the management team.
- The management team made themselves accessible to staff by being available when needed, being open and transparent in their engagement with the staff at the centre.
- Staff we spoke with said they felt able to raise concerns and were confident that they would be dealt with appropriately.

Summary of this inspection

- We saw evidence of patient and staff engagement. The service demonstrated that patient experience was the key factor for their service development.

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

Requires improvement

Diagnostic imaging

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

Are diagnostic imaging services safe?

Requires improvement

Mandatory training

- **The service provided mandatory training in key skills to all staff. However, staff did not always complete mandatory training.**
- The mandatory training requirements included courses basic life support, infection control, fire safety, manual handling, health and safety, risk assessments, equality and diversity, safeguarding children and vulnerable adults level 2, data protection and General Data Protection Regulation (GDPR) and conflict resolution.
- Staff mandatory training was completed either face to face or through an electronic learning program (e-learning). The service had a training matrix with a 'traffic light' system which would alert the practice manager when training was due to be complete.
- The training matrix had 11 staff members and there were three managing partners. All staff (100%) had completed training in basic life support and data protection and GDPR, 86% had completed fire safety, manual handling and health and safety and 55% conflict resolution.
- The managing partners for the service were not included on the training matrix. The practice manager told us the managing partners had completed mandatory training with their substantive NHS employer. The service had practising privileges policy which outlined the responsibilities for completing mandatory training. We noted the policy was due to be reviewed in 2008 and had not been updated. The policy did not state the partners needed to provide evidence of completion of mandatory training to the service. There was no procedure to be followed if this evidence was not provided.

Safeguarding

- **The service did not have a designated safeguarding lead. Staff working with young people had not completed training in safeguarding children at level three.**
- The service had a safeguarding children and vulnerable adult's policy including guidance on female genital mutilation. We noted the policy needed to be updated to include current guidelines- such as child sexual exploitation, actions to be taken and who to contact in the event of adult or child safeguarding concern. Staff had access to the safeguarding policy which was stored in the practice managers office.
- The service did not have a designated safeguarding lead trained to level three in safeguarding children.
- All the staff we spoke with demonstrated they understood safeguarding processes and how to raise an alert. They could access support from senior staff if needed. Staff were aware of their responsibilities to protect vulnerable adults and children.
- The service had an up to date chaperone policy. Staff were available for any patient requiring chaperoning.
- Safeguarding children and vulnerable adults formed part of the mandatory training programme for staff. Staff we spoke with told us they had received safeguarding training. Records provided by the service showed that 79% (11/14) of staff had completed safeguarding children and vulnerable adults level 2 training. The managing partners had completed training with their substantive NHS employer. The service treated six young persons between the age of 16 – 17 years in the

previous 12 months. Staff working with young people had not completed training in safeguarding children at level three. The practice manager told us training in safeguarding children level three would be added to the mandatory training requirements.
- We were informed there had been no safeguarding referrals in the previous 12 months.

Cleanliness, infection control and hygiene

- **Although systems were in place to control the risk of infection and the equipment and premises were visibly clean, the service did not have the processes to confirm this. The service did not always use control measures to prevent the spread of infection.**
- The centre provided staff with personal protective equipment (PPE) such as gloves. Staff told us they wore PPE where necessary. We noted all staff adhered to the 'bare below the elbows' protocol in clinical areas.
- Hand-washing and sanitising facilities were available for staff and visitors in the centre. Posters prompting appropriate hand washing technique were clearly displayed. Alcohol-based hand cleaning gels were available for patients and staff to clean their hands. Within the consultation rooms a hand washing sink was available to ensure that hands could be washed before and after patient contact.
- The service had an up-to-date procedure for cleaning ultrasound probes. Staff demonstrated good knowledge of the Society of Radiographers ultrasound probe decontamination and disinfection guidance. The service did not have a cleaning checklist for the ultrasound probes and could not be assured the correct cleaning procedure was always followed. Staff told us the cleaning of the premises was done by an in-house cleaner. The service did not have a cleaning checklist for the premises.
- The service had an infection control policy. We noted the policy had not been updated since 2013. The practice manager told us they were in the process of updating all the practice policies. Following our inspection we received confirmation of an updated infection control policy.
- Waste was separated and disposed of in line with best practice guidance. The service had a contract with a clinical waste company.
- The service used single use equipment where appropriate. We checked the ultrasound gel being used and found it was within the expiry date.
- The service did not have a suitable Control of Substances Hazardous to Health (COSHH) policy and procedures for staff to follow. COSHH risk assessments were not undertaken. Following our inspection, the service sent us evidence of COSHH completed risk assessments.
- Sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw sharps containers were used appropriately and they were dated and signed when brought into use. We noted the service did not have a sharps injury policy to provide guidance of the management of sharps injury including relevant numbers to contact.
- Infection control training formed part of the mandatory training programme for staff. Data provided by the centre showed that staff 57% had completed infection control training. The practice manager told us the remaining staff would complete infection control training in December 2018.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
- The consultation rooms were all well-equipped including the clinical equipment required.
- The premises had undergone renovations within the last 12 months including new electrical installation, flooring and furnishing. The service had also replaced two ultrasound machines.
- Staff told us all equipment's used at the centre were serviced annually and maintained by a recognised service team. There was an effective system to ensure that repairs to broken equipment's were carried out quickly so that patients did not experience delays to treatment.
- Servicing and maintenance of premises and equipment was carried out using a planned preventative maintenance programme. During our inspection we checked the service dates for all equipment which were within the last 12 months. There was a contract for the servicing of the equipment which was dated 01 November 2018 and was valid for five years.

Requires improvement

Diagnostic imaging

- Failures in equipment and medical devices were reported to the practice manager and action was taken promptly. Staff told us there were usually no problems or delays in getting repairs completed. All equipment conformed to the relevant safety standards.
- All electrical equipment had been tested for safety and the premises had an electrical safety check.
- We reviewed the equipment used in the management of a medical emergency. The service had a pocket mask only and did not have any medicines for use in the event of a medical emergency. The service had a policy for medical emergencies which stated staff should call 999 and perform Cardiopulmonary resuscitation (CPR) until the ambulance arrives. The service had not risk assessed the emergency medicines and equipment to ensure it was in line with guidance issued by the Resuscitation Council.
- There was a clear pathway to replenish consumables and to avoid stock depletion. Supplies were replenished frequently to avoid shortages and staff told us they could request additional supplies if they were low before the next re-stock.
- The service had a health and safety policy which had been updated in 2017. A health and safety risk assessment had been undertaken in November 2018.
- There was good access to the centre by car and public transport. The reception area was clean and tidy with access to magazines toilet facilities for patients and relatives.
- There was adequate seating and space in the reception area.
- The service was registered to receive safety alerts from Medicines and Healthcare Products Regulatory Agency (MHRA). The service did not have evidence to show safety alerts were regularly reviewed.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.**
- The service had referral criteria which was reviewed for each patient at the time of booking the appointment or receipt of referral. The criteria were developed by the provider to ensure it could meet the needs of patients who wished to use the service.
- A three-point check was completed prior to a diagnostic test which was in line with best practice. Staff confirmed patients had their name, address and date of birth checked before starting an investigation.
- There was evidence of closing the loop and ensuring referrers act on any urgent or unexpected findings on reports. Staff would contact the referrer and follow this up with an urgent report.
- The service had an up-to-date fire evacuation plan. A fire risk assessment had been undertaken in November 2018 and there was an action plan. Staff undertook fire safety and evacuation training. Data provided by the service showed that 86% of staff had completed fire safety and evacuation training. Staff could explain the evacuation procedure and were aware of where the fire extinguishers were located. The fire equipment, including the fire alarm, was checked on a weekly basis. There was bi-annual fire evacuation exercise which ensured staff were kept up to date on their responsibilities in the event of a fire. Fire extinguishers were readily available and fire exits were clearly signed.
- The service had a policy for the emergency management of cardiopulmonary resuscitation. All staff had received basic life support training. Refresher training was due to take place in December 2018.

Medical staffing:

- The three managing partners were consultants who had contracts with their substantive NHS employer. Each of the three partners covered a weekday at the service.

Nurse staffing

- The service did not employ nursing staff.

Diagnostic imaging staff

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment**.
- The service had one full time sonographer and five part-time sonographers who covered one day of the week each. The consultants and sonographers were responsible for the care of their patients.
- The service did not use any bank or agency staff, preferring to cover any unexpected vacancies with the clinic's own staff.
- Staff worked flexibly to ensure appropriate staffing was maintained.

Requires improvement

Diagnostic imaging

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**
- Patient records were managed in a way that kept patients safe and protected their confidential and sensitive information from being shared incorrectly. Staff used electronic patient records to record patient's diagnostic needs.
- All patient's data, medical records and scan results were documented via the service's patient electronic record system. Electronic records could only be accessed by authorised personnel. Computer access was password protected and staff used individual log-ins.
- The service provided electronic diagnostic imaging reports which were encrypted.
- The service received patient's referrals through a secure email or telephone call from the referring consultant or hospital.
- The service was registered with the Information Commissioner's Office (ICO).
- We reviewed six patient records and found that these had all been fully and clearly completed.
- Staff had received training on data protection and GDPR. Records provided by the service showed that all staff (100%) had completed training.

Medicines

There were no controlled drugs or medicines kept within the service.

Incidents

- **The service did not manage patient safety incidents effectively. Although staff recognised incidents, reported them appropriately and managers investigated incidents, the managers did not share lessons learned with the whole team to prevent similar incidents in the future.**
- The service had an accident book. Staff could identify and describe situations requiring completion of an incident form. Staff told us there was a good reporting culture.
- There was one incident in the last 12 months. The incident was a sharps injury which was recorded and investigated. Patient safety was not promoted through shared learning as the incident was not discussed with the wider team.
- There had been no serious incidents reported in the last 12 months.
- The service did not have a duty of candour policy. Staff we spoke with understood the duty of candour requirements. Staff explained that they would inform patients if an incident occurred which meets the requirements of duty of candour, apologise and undertake an investigation. Staff could give an example of an incident where the duty of candour requirements had been applied at a different location. Following our inspection, the service sent us evidence of a duty of candour policy.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

Are diagnostic imaging services effective?

We do not rate the effective domain.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.**
- Care and treatment was delivered to patients in line with National Institute for Health and Care Excellence (NICE) and Royal Colleges guidelines. Staff told us they followed national and local guidelines and standards to ensure effective and safe care.
- Staff followed the Fetal Anomaly Screening Programme (FASP) guidelines and the service kept a copy of the handbook. Audits were completed to ensure staff met the FASP guidelines. There were protocols for obstetrics including first trimester scanning, detailed anomaly scanning, fetal wellbeing scanning and a referral to the fetal heart clinic. Gynaecology had a pelvic scanning protocol and for administration there was a standard operating procedure. Health and safety protocols included cleaning the ultrasound probes and the safe handling and transfer of specimens.
- Sonographers submit images to the Fetal Medicine Foundation on an annual basis to gain a nuchal

translucency licence. Nuchal translucency is the sonographic appearance of a collection of fluid under the skin behind the fetal neck in the first-trimester of pregnancy. We saw records which showed that five sonographers had a nuchal licence.

Nutrition and hydration

- Patients requiring specific scans whereby a full bladder was required, were provided with sufficient information about how much to drink before coming to their appointments.

Patient outcomes

- **Managers monitored the effectiveness of care and treatment and used the findings to improve them.**
- The service had an audit programme which focused on the crown, rump length (CRL) audit based on the Fetal Anomaly Screening Programme (FASP) and the nuchal translucency (NT) audit. The service set a target of 75% for the CRL and NT audit and all sonographers had exceeded this target. The CRL audit reviewed gestation and development in the early stages of pregnancy (before 12 weeks). The NT audit quality assured images and checked that the measurements were correct. Audits were completed on a quarterly basis for each clinician who were provided with a report on the findings.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.**
- Sonographers do not have a protected title and are therefore not required to be registered with the Health and Care Professions Council (HCPC). However; radiographers that have an extended scope in sonography are required to be registered with the HCPC. Records provided by the service showed that four staff were registered with the HCPC.
- Staff were required to complete continuing professional development training to maintain registration with the HCPC. Staff attended courses such as ultrasound diagnosis, effective prenatal screening of congenital heart disease, world congress on ultrasound for obstetrics and gynaecology and basic fetal echocardiography.
- The practice manager reported that most staff had received an appraisal. Records provided by the service showed that 43% of staff had completed appraisals in the last 12 months. The remaining staff members had dates arranged to complete their appraisals. Staff told us appraisals were valuable in their professional development. Staff discussed and agreed their learning needs during appraisal.
- There was a practicing privileges policy. The policy did not require all managing partners to provide evidence of a satisfactory appraisal. There was no procedure in place if this evidence was not provided.
- The practice manager told us they reviewed all staff competencies as part of the appraisal process. Records showed that the consultants, who were the managing partners, and sonographers had appropriate skills, knowledge and experience to carry out their roles effectively.
- Staff told us they had good access to training regarding their professional development. Staff could identify their own developmental areas independently and with support.

Multidisciplinary working

- **Staff of different grades worked together as a team to benefit patients. Doctors and other healthcare professionals supported each other to provide good care.**
- The service had a close working relationship with the patient's general practitioner and various labs. The service liaised with the labs regarding patients' blood tests, facilitated the tests and sent the results on to the referrer.
- Staff we spoke with told us they had good working relationships with other sonographers and the consultants. This ensured that staff could share necessary information about the patients and provide holistic care.
- Staff gave us examples of occasions when they liaised with the referrer. For example, one patient who attended for ovarian cancer screening where an abnormality was detected. The referrer was immediately contacted and the patient had a Magnetic Resonance Imaging (MRI) test with another provider.
- We heard positive feedback from staff about the excellent teamwork.

Seven-day services

Requires improvement

Diagnostic imaging

- The service is opened Monday to Friday 9am – 5pm.
- Appointments were flexible to meet the needs of patients, including appointments at short notice.
- Referrals were prioritised by clinical urgency. Staff told us if an urgent referral was made the centre would assess appointments and prioritise patients according to their clinical needs and requirements of the referring practitioner.
- Patients are advised to contact the service in the event of an emergency outside of normal opening hours. The centre manager told us patients could speak to the consultants to discuss any concerns.

Health promotion

- The managing partners had given evening lectures to general practitioners and other consultants to raise awareness on pre-eclampsia screening and the failure to reach growth potential.
- The service had information leaflets on fetal wellbeing scans, screening for chromosomal abnormalities and non-invasive prenatal testing.

Consent and Mental Capacity Act

- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.**
- Patients gave consent prior to an intervention. Staff understood their role in identifying patients who did not have capacity to consent.
- There was a process to ensure verbal consent was gained before an intervention commenced. Patients were provided with information about their procedures before their appointments. They were provided with sufficient time to ask any questions before they had their procedures. This gave an opportunity to gain verbal consent before the scan.
- The service had patient information leaflets on screening for chromosomal abnormalities, fetal wellbeing scan and non-invasive prenatal testing
- The sonographers and consultants understood 'Gillick' competencies for patients under the age of 18 years. To be Gillick competent, a young person 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.
- Staff understood their roles and responsibilities in obtaining consent and their responsibilities under the Mental Capacity Act 2005.

Are diagnostic imaging services caring?

Good

We rated it as **good.**

Compassionate care

- **Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.**
- We observed staff being kind and compassionate as they put patients and their relatives at ease. Patients were treated with dignity and respect. Staff welcomed patients into the centre and directed them to diagnostic imaging rooms.
- We spoke with two patients during the inspection. Patients who spoke with us were positive about how they were treated during their contact with the centre. Patients told us they did not feel rushed at appointments and they had enough time to ask staff questions. Patients commented on being able to see the same consultant or sonographer at their subsequent appointments that had in-depth knowledge of their treatment history.
- Clerical staff in clinics assisted patients promptly and were friendly and efficient in busy clinics. We observed the consultants greeting the patients in the reception area before taking them into the consultation room.
- The service had completed a patient satisfaction survey between October to November 2018 and received 53 responses. The results showed that 94% of patients would recommend the service to friends, 100% found the staff welcoming and helpful, 100% found the waiting area and clinic room clean and 100% were given adequate information about their scan and what to expect. Patients commented, "the lady at reception was lovely and the senior radiographer was absolutely marvellous, very polite, patients and thorough." Other patients stated, "the quality of the scans and the number of pictures given were very satisfactory" and "lovely staff, always friendly, always call to confirm appointments. I wouldn't go anywhere else."

Diagnostic imaging

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- Staff were fully committed to working in partnership with patients. Staff always empowered patients to have a voice. For example, staff discussed the treatment and its benefits with the patient. The patient was actively involved in their care and determining the final treatment plan.
- Staff provided emotional support to patients to minimise their distress for example patients with anxiety. Support included giving the patients as much time as they needed to discuss their concerns, talking in a calm and reassuring way. We saw this during the inspection. Staff were very patient, kind and provided anxious patients with the reassurance they needed.
- Patients were given time to ask questions after their scan and staff provided clear the required information in a way that was easy to understand.
- Staff understood the impact that patients care, treatment and condition had on the patient's wellbeing. Staff we spoke with stressed the importance of treating patients as individuals.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- The service had a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Patients were actively involved in their care.
- Staff communicated with patients so that they understood their care, treatment and condition. Patients told us staff communicated well with them and helped them to understand their care and treatment. They said they were given written information to explain their scan.
- Patients who spoke with us reported feeling involved and understood what they were attending the service for, the types of investigations they were having and the expected frequency of attendance.
- Patients said the staff were thorough, took time to explain procedures to them and they felt comfortable and reassured. Patients felt they were given adequate information.
- Patients were provided with a copy of their scan after their examination.

Are diagnostic imaging services responsive?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

- **Patient's individual needs and preferences were central to the planning and delivery of the service. The services were flexible and provided patients with choice. The service provided diagnostic imaging tests for private patients.**
- The service provided planned diagnostic treatment for patients at their convenience.
- Comments we reviewed showed patients were given enough time to ask questions and be involved in their care. The patient satisfaction survey showed that most patients were seen on time. Patients commented, "they always run on time" and "I didn't have to wait".
- Staff told us that patients appreciated the accessibility of the service.
- The environment was appropriate and patient-centred. There was a comfortable seating area, and toilet facilities for patients and visitors.
- We observed that patients were seen promptly and that patients could book the next available appointment with their chosen consultant or sonographer. Staff told us that patients were seen promptly following referral and there were no waiting lists.
- Patients were provided with appropriate information about their visit including directions to the waiting area of the centre.

Meeting people's individual needs

- **The service did not always account for patients' individual needs. The service did not have a procedure for treating patients with a learning disability, dementia or bariatric patients. The service had not considered the needs of these patient groups.**
- The centre was compliant with the Disability Discrimination Act 1995. The main reception area was

on the ground floor. Patients were directed to the service's reception area and imaging rooms in the basement. The service had an elevator, a low-level reception desk and a fully accessible toilet. Ramps were installed to enable wheelchair users or people with limited mobility to gain entrance to the building.

- The service did not have access to an interpreting service for those whose first language was not English. Staff told us whenever necessary patients would attend with an interpreter.
- Patients were referred via their consultants or general practitioners and staff told us patients also self-referred. Appointments were made by booking directly with the service. Staff said that all patients were seen promptly and patients rarely had to wait for an appointment.
- Patients we spoke with told us there was no difficulty in arranging a suitable appointment.
- Staff spent time with patients prior to their scan offering reassurance, as well as time for the patient to settle before imaging commenced.
- The service did not have a procedure for treating patients with a learning disability, dementia or bariatric patients. The service had not considered the needs of these patient groups. Staff told us these patients were not routinely seen at the service.

Access and flow

- **People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with best practice.**
- Staff told us patients are generally offered appointments within 24 hours. However, the service did not have evidence to show this data was collected and monitored.
- Patients were offered a choice of appointment times. Patients we spoke with told us they were given appointment times that suited them. The service planned to scan patients at the time of their choice and had confirmation discussion with the patient about whether they wanted a morning or afternoon appointment.
- Patents were happy with reporting times. Diagnostic reports were usually made available on within 24 hours depending on the urgency of the request and investigation.
- Referrals were prioritised by clinical urgency. Staff told us if an urgent referral was made the service they would assess appointments and prioritise patients according to their clinical needs and requirements of the referring consultant.
- The service ran on time and staff informed patients when there were disruptions to the service. All patients we spoke with said there was minimal waiting time when visiting the service.
- Staff confirmed that where patients missed their appointments they were contacted immediately and offered the next available appointment as needed.

Learning from complaints and concerns

- **The service had a system for capturing and investigating complaints.**
- The service had a complaints policy which stated complaints would be acknowledged within two days and investigated within five days. One of the managing partners was the complaints lead.
- The complaints policy was a two stage rather than a three-stage process. At the first stage the complaint would be investigated by the practice manager and at the second stage by the managing partner. We noted the policy did not list the correct organisation for patients to complaint to if they were not satisfied with the service's response. Complaints of this nature should be referred to the Independent Sector Complaints Adjudication Service (ISCAS) who could provide guidance, assistance and arbitration when necessary.
- Information on how to make a complaint was not readily accessible to patients. For example, patient leaflets or a notice in the reception area.
- The practice manager told us the service had not received any formal or informal complaints in the previous 12 months.

Are diagnostic imaging services well-led?

Requires improvement

We rated it as **requires improvement.**

Leadership

- **Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.**

- The service had a clear organisational structure with three managing partners who shared responsibility for the clinical leadership. The practice manager had overall responsibility for the for the day to day running of the service. Staff knew the management arrangements and their roles and responsibilities.
- We observed members of staff interacting well with the leadership team during the inspection. Staff told us managers were open, approachable and very supportive.
- The managing partners were visible, and worked in the service regularly which provided continuous visibility.
- The leadership team were very committed to the staff, the patients and the service. This was reflected in the way the led their small team and kept patients at the heart of service delivery. They also felt strongly about trusting and empowering the staff team, and advocated an autonomous approach to the work undertaken.

Vision and strategy

- The service did not have a documented vision and strategy. Following our inspection, the service sent us a vision and strategy. The vision was to provide a comprehensive and reliable service in obstetric and gynaecological ultrasound scanning. The objectives were to meet the vision with staffing, knowledge and equipment by ensuring the highly-trained team keep abreast of all the latest techniques and applications, using the best technologies related to pregnancy and gynaecological assessments and to continue to invest in technology.

Culture

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- Staff described the culture of the service as open and transparent where staff supported each other.
- Staff we spoke with were proud of the work that they carried out. They enjoyed working at the service; they were enthusiastic about the care and services they provided for patients. They described the service as a good place to work. Some of the staff we spoke with had worked for the provider for many years and were enthusiastic about the services offered and the care that was provided.
- All staff reported they felt supported by the practice manager and the wider organisation when incidents or other issues occurred. Staff reported that there was a no blame culture when things went wrong.
- The management team and staff were committed to continuous improvement of the service.

Governance

- **The service did not always improve service quality and safeguarded high standards of care. The service did not complete audits, staff meetings and monitor performance.**
- The service's clinical governance structure included quarterly partners meetings. We saw records of these meetings which discussed financial planning, performance, clinical issues and audits. There was an annual general meeting (AGM) and all staff were invited to attend to discuss administrative and clinical issues. The last in June 2018 records showed that the team discussed gaining further multidisciplinary experience by working at a hospital in London, first trimester screening and General Data Protection Regulation. Meetings were minuted and disseminated to all staff so those not in attendance could consider topics discussed.
- The service did not have regular staff meetings. This would have been an opportunity to discuss the learning from incidents to prevent recurrence in future.
- There was a staff communication book where staff would write notes to each other or the management team. A staff noticeboard was in the practice manager's office. It contained notices for upcoming internal and external courses and relevant clinical research papers.
- The service had effective systems to monitor the quality and safety of the service. The use of audits, risk assessments and recording of information related to the service performance was to a high standard. The service had completed two clinical audits in the last 12 months.
- The service had not undertaken infection control or hand hygiene audits.
- The practice manager was articulate about the running of the service and had a clear understanding about the quality of service to be provided.
- The service had a recruitment procedure. The practice manager told us that, as part of the staff recruitment process, they carried out appropriate background checks. This included a full Disclosure and Barring Service (DBS), proof of identification and references. We

reviewed the staff files and found that DBS and proof of identification checks had been carried out for all staff. However, references were not always completed. The service did not have complete immunisation records showing immunity to Hepatitis B for clinical staff. Following our inspection, the service sent us evidence of immunisation for seven out of nine clinical staff.

- Policies and procedures were not reviewed regularly and updated where required. There were several policies written in 2005, with various review dates, that had not been reviewed. The practice manager told us the policies were in the process of being updated. We saw records which showed that policies such as health and safety, fire safety and information governance had been reviewed in 2018.
- Not all sonographers within the service had professional indemnity insurance. The practice manager told us sonographers were having difficulty sourcing suitable professional indemnity insurance. Independent sonographers are required to have suitable professional indemnity in place so they are protected if a medical negligence claim is made against them. Patients using an independent sonographer have an expectation that professional indemnity cover is in place should they need to make a claim.

Managing risks, issues and performance

- **The provider did not have an effective system for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.**
- The service did not have a risk management strategy, setting out a system for continuous risk management. The service did not have a risk register. The service had not completed a risk assessment for COSHH, health and safety, Legionella, management of medical emergency equipment and medicines. Risk assessments had been completed for fire and lone working.
- Staff understood the incident reporting procedure and the requirements of the duty of candour.
- The service did not have a business continuity plan that could operate in the event of an unexpected disruption to the service. This would include the steps to be taken if there is potential disruption, such as fire or telecommunication system failure.
- Safety alerts had not been regularly reviewed.

Managing information

- **The service did not always collect, analyse, manage and use information well to support all its activities, using secure electronic systems with security safeguards.**
- All staff had undertaken data security and awareness training as part of their mandatory training. All staff had completed training on the General Data Protection Regulation (GDPR). Staff we spoke with understood their responsibilities around information governance and risk management.
- All staff we spoke with demonstrated they could locate and access relevant policies and key records very easily and this enabled them to carry out their day to day duties successfully.
- Electronic patient records could be accessed easily and were kept secured to prevent unauthorised access of data.
- Information from scans could be reviewed remotely by referrers to give timely advice and interpretation of results to determine appropriate patient care.
- The service stored most information electronically and this was encrypted before being sent. This meant the service could easily collate and audit the data and use this information to improve the quality of care delivered.
- Staff reported no concerns about accessing relevant patient information. Staff had access to all the information they needed to deliver care and treatment to patients in an effective and timely way.

Engagement

- **The service engaged well with patients, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.**
- The service had completed a patient satisfaction survey and received positive feedback.
- The service had a website that provided information to patients on the investigations provided, the fees, location and details on how to make an appointment.
- Care was provided by a small and well-integrated team. This meant, staff engagement happened daily and was not formalised.

Learning, continuous improvement and innovation

- The managing partners were consultants at a London hospital. They had given evening lectures to raise awareness on pre-eclampsia screening and the failure to reach growth potential.

Requires improvement

Diagnostic imaging

- The service had plans to set up a screening programme for pre-eclampsia by regularly monitoring patients' blood pressure.

Outstanding practice and areas for improvement

Outstanding practice

- The managing partners were consultants at a London hospital. They had given evening lectures to raise awareness on preeclampsia screening and the failure to reach growth potential.
- Sonographers submit images to the Fetal Medicine Foundation on an annual basis to gain a nuchal translucency licence. Nuchal translucency is the sonographic appearance of a collection of fluid under the skin behind the fetal neck in the first-trimester of pregnancy. We saw records which showed that five sonographers had a nuchal licence.

Areas for improvement

Action the provider MUST take to improve

- Ensure there is suitable professional indemnity insurance in place to cover the activities provided by the service.
- Ensure there is a designated safeguarding lead with training in safeguarding children at level three.

Action the provider SHOULD take to improve

- Ensure there is an effective risk management system for monitoring and mitigating the various risks arising from the undertaking of the regulated activities.
- Ensure policies and procedures are reviewed regularly and a version control system is implemented.
- Ensure infection control and hand hygiene audits are completed to make sure staff are compliant with infection control guidelines and policies.
- Ensure there is an effective system for reviewing incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.
- Review the service's recruitment policy and procedures to ensure accurate, complete and detailed records, such as references and evidence of immunisation against Hepatitis B, are maintained for all staff.
- Ensure there is an effective system, such as staff meetings, to share learning and practice with staff.
- Ensure the service monitors performance by collecting and analysing data and using the results to improve patients experience.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. We noted: • The provider did not ensure there was suitable professional indemnity insurance to cover all activities. • The service did not have a designated safeguarding lead with training in safeguarding children at level three. Regulation 17(1) (2)(b)