First View Imaging Limited

Quality Report

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

Ratings

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

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

First View Limited is an ultrasound imaging service, operated by the provider, also known as First View Imaging Limited. The service offers ultrasound pregnancy scans and abdominal, gynaecological and fertility scans to the whole population. In practice, they offered services to men and women over 16 years of age. It has one ultrasound machine, and two waiting rooms.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 18 June 2019, and spoke with eight patients by phone on 19, 20 and 21 June 2019.

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. For this type of service, we do not rate effective.

This was the first time this service had been rated. We rated it as **Good** overall.

We found good practice in relation to diagnostic and imaging:

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Staff completed their mandatory training and competency assessments.
- The service controlled infection risk well and kept equipment and premises visibly clean. It maintained safe premises and equipment, and managed clinical waste and blood samples well.
- Staff identified and completed risk assessments for each patient and removed or minimised risks. They created records that were accurate and detailed, and staff kept these accessible and secure.
- There had been no recorded patient safety incidents in the past 12 months. Staff recognised incidents and near misses and understood how to apply the duty of candour.
- The service provided care based on national guidance and evidence-based practice. All staff were committed to continually learning to improve their service.
- The service had an agreement with healthcare staff at a nearby NHS trust and based their policies on trust policies. Staff worked collaboratively to support patients though their health care.
- The service monitored the effectiveness of the care their staff delivered and used findings to make improvements and achieve good outcomes for patients.
- Staff supported patients to make informed decisions about their care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs. This was confirmed by the patients we spoke with and by patient feedback obtained by the provider.
- Staff provided emotional support and supported patients and their family to understand procedures, results and the next steps in their care.
- The service planned and provided care in a way that met the needs of the local people. It also worked with other health providers to plan care.
- The service took account of patients' individual needs and preferences. It offered appointments at times that suited patients and patients said they didn't have to wait on arrival for their appointment.

Summary of findings

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.
- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced and staff and patients told us they were visible and approachable.
- The service had a vision for what it wanted to achieve.
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet with the directors, discuss service plans and learn.
- Leaders and staff actively and openly engaged with patients, staff and other health providers. They collaborated with partner organisations to help improve services for patients.

We found areas of practice that should be improved:

- Staff took action in response to incidents, but they did not always record these actions in a systematic way.
- The service undertook hand hygiene audits and advised staff of shortfalls but did not record the action required on the audit report.
- There was no programme of regular audits of sonographer practice, to ensure they followed best practice guidance.
- The service did not have access to translation services for those patients for whom spoken English is not their first language.
- Some of the service's policies and procedures were not dated and did not incorporate enough detail to provide guidance for staff. Despite this, staff understood what actions to take in relation to the topics covered, such as information management and safeguarding, and the service did not use bank or agency staff.
- There was evidence that risks had been identified and managed, but these were not formally recorded within a risk management framework.
- Office staff did not have annual appraisals, for the discussion of performance and development.

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

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	This was a limited company offering an ultrasound diagnostic imaging service. We rated this service as good because it was safe, caring, responsive and well led.

Summary of findings

Contents

Good

Location name here

Services we looked at
Diagnostic imaging

Summary of this inspection

Background to First View Imaging Limited

First View Limited is operated by the provider known as First View Imaging Limited. The service was first registered with CQC in 2011 and has been in operation for 15 years. It is a private service in Fareham, Hampshire, and primarily serves the communities of Portsmouth and the surrounding areas of south Hampshire. It also offers care to patients from outside this area.

The registered manager, one of three directors of the company, had been in post since registration in 2011.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected three times, and the most recent inspection took place in February 2014, where we found it was compliant with the two regulations previously judged as non-compliant.

Our inspection team

The team that inspected the service comprised a CQC lead inspector overseen by Amanda Williams, Head of Hospital Inspection.

Information about First View Imaging Limited

The service is registered to provide the following regulated activity:

- Diagnostic and screening procedures.

First View Imaging Limited is a private ultrasound clinic that provides ultrasound examinations for abdominal, gynaecological and obstetric scans. Patients self refer to the service, and sometimes health professionals advise a patient to contact the service if they wish to have a specific scan at a specific time. The service is open six days a week.

During the inspection, we visited all areas within the clinic. We spoke with the registered manager, who was a sonographer as well a director of the service, a member of the office staff and another director. We spoke with two patients during the onsite visit and eight by phone later in the week. After the inspection we spoke by phone with the third director, one of the two phlebotomists and a GP whose patients had used the service. During our inspection, we reviewed five sets of patient records.

Activity (April 2018 to March 2019)

- All patients who attended for an ultrasound scan were private patients.
- Two of the three directors were sonographers and one carried out an administration role. The service employed or had sessional contracts with one further sonographer, two phlebotomists and four office staff, all on a part time basis.

Track record on safety

- Zero never events, clinical incidents, serious injuries
- Zero incidences of hospital acquired infections

The service had received one complaint.

Services accredited by a national body:

- There are no services accredited by a national body.

Services provided under contract:

- Clinical and non-clinical waste removal
- Maintenance of ultrasound equipment
- Non-invasive prenatal testing analysis
- HSE advice

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

This was the first time this service has been rated. We rated safe as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and worked well with other agencies to do so. Staff received training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste and blood samples safely.
- Staff identified and completed risk assessments for each patient who attended an ultrasound diagnostic test and removed or minimised risks. They checked the identity of the patient, and the reason they requested a procedure, to make sure they could provide a relevant and appropriate service.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service had no recorded patient safety incidents in the past 12 months.

However, we also found the following that the service provider should improve:

- Action was taken in response to hand hygiene audits, but this was not noted on the audit reports.
- Action was taken in response to incidents, but this was not always recorded in a systematic way.
- Policies and protocols were not consistently detailed. The safeguarding policy did not refer to all aspects of abuse, for example it did not include reference to female genital mutilation. The emergency protocol did not include what action to take in response to a cardiac arrest.

Summary of this inspection

Are services effective?

We do not rate effective for this type of service.

- The service provided care and treatment based on national guidance and evidence-based practice. The sonographers updated their protocols based on those used at a local NHS trust and followed manufacturer guidance for carrying out non-invasive prenatal tests.
- The service issued patients with guidance on how to prepare for their scan.
- Staff monitored the effectiveness of care and treatment from patient feedback. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Sonographers assessed each other's work and liaised on improving practices and procedures. The registered manager also worked in the same role within a local NHS trust and used this experience to support staff practices.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients to make their own decisions, including those who were experiencing mental ill health.

However, we also found the following that the service provider should improve:

- There was no process for formally auditing the sonographers' practice.

Are services caring?

Good

This was the first time this service has been rated. We rated it as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. This was confirmed by patients we spoke with and feedback collated by the provider.
- Staff provided emotional support to patients and their families to minimise their distress. They understood patients' personal needs and made sure they gave patients time to understand results and findings.
- Staff supported and involved patients and families to understand the procedure, the results of a scan or test and make decisions about their care and treatment.

Summary of this inspection

Are services responsive?

Good

This was the first time this service has been rated. We rated it as **Good** because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed to or when it was convenient and received the right care promptly. People did not have to wait long to be scanned.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

However, we also found the following that the service provider should improve:

- The service should have access to translation services for those patients for whom spoken English is not their first language

Are services well-led?

Good

This was the first time this service has been rated. We rated it as **Good** because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable and supported staff by being onsite and available.
- The service had a vision for what it wanted to achieve.
- Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities and had opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams identified and managed relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- The information systems were integrated and secure.
- Leaders and staff actively and openly engaged with patients, staff and other health providers. They collaborated with other healthcare staff to help improve services for patients.
- All staff were committed to continually learning and improving services

Summary of this inspection

However, we also found the following that the service provider should improve:

- Their systems for quality and safety were not consistently formalised, such as those relating to risk management and audit, to evidence actions taken.
- Some of the service's policies and procedures were not dated and did not incorporate enough detail to provide guidance for staff. Staff understood what actions to take in relation to the topics covered, such as information management and safeguarding.
- Not all staff had the opportunity for an annual appraisal.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	N/A	Good	Good	Good	Good

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Good

This was the first time this service had been rated. We rated safe as **good.**

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- All staff received and were up to date with their mandatory training. This included topics such as health and safety, safeguarding level 2 for adults and children, infection control, information governance, complaints, epilepsy, fire safety and conflict resolution and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.
- The mandatory training met the needs of patients and staff.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.** Staff had training on how to recognise and report adult and child abuse and they knew how to apply it**.**
- The service had links with and contact details for the safeguarding team and lead at a local NHS trust for advice. It also had the contact details for the local authority safeguarding team. All staff received training on how to recognise and report abuse.
- Safeguarding information was on display within the service, where patients could see it.
- Staff knew how to identify adults and children at risk of, or suffering from, significant harm and worked with other agencies to protect them. The registered manager summarised a case they had reported over 12 months previously. They were aware of what actions to take should they have concerns relating to female genital mutilation, child sexual exploitation or modern slavery, however this was not explicit in the service's safeguarding policy.
- The service would not scan patients presenting under the age of 16, and asked all women attending for a pregnancy scan to bring their NHS notes, which contained their personal identification details.
- The service had not raised any safeguarding concerns within the last 12 months.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well.** Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- All areas appeared visibly clean. The ultrasound room had washable flooring and wipe-clean furnishings. The service used fresh paper towelling on the couch for each patient. The waiting room and reception area were carpeted, and the carpet appeared clean and intact.
- Cleaning records were up to date and demonstrated that all areas were cleaned regularly.

- There were a small number of children's toys and books in the waiting room, and the staff checked these were clean and in a good condition when setting up the room each day.
- There was a handwash basin in the ultrasound room and access to hand disinfectant. Handwashing guidance was posted above the basin and the service in line with World Health Organisation's "Five moments for hand hygiene" to remind staff of hand hygiene in line with best practice. The service had a patient toilet which was clean and well-maintained.
- Staff followed infection control principles including bare below the elbow and the use of personal protective equipment (PPE) such as gloves. They used a specific cleaning agent for the transvaginal probe and probe covers.
- The registered manager was the appointed lead for infection control and the audits were carried out by her or another sonographer.
- The service carried out monthly hand hygiene audits on different staff members. The audit reports showed staff almost always washed their hands or used alcohol gels before and after contact with patients, and after contact with patient surroundings. The audit reports did not make it clear what action was taken in response to non-compliance, however we were told staff were reminded to follow the agreed hand hygiene protocols. The registered manager decided to amend the audit forms to make learning clearer.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe.** Staff managed clinical waste and blood samples safely.
- The clinic was on the ground floor and the service was equipped with a security alarm. The ultrasound equipment was maintained under an annual maintenance contract, which included a 24-hour replacement/repair agreement. The equipment had an automated safety check on start up.
- Staff disposed of clinical waste safely. Clinical waste bags and sharps boxes were collected under contract with an external company. Clinical waste was disposed of into yellow bags and the service had a correctly assembled sharps box to dispose of needles used for the non-invasive prenatal test (NIPT). The NIPTs can be used to assess if a woman's fetus is at a higher chance of having certain genetic and chromosomal conditions, using a venous blood sample taken from the pregnant woman. It is referred to as non-invasive because it does not involve the insertion of a needle into the woman's abdomen or cervix, as is the case with more invasive testing where cells are taken from the amniotic sac or placenta.
- The service used two companies for NIPTs and each had their own packs and processes for labelling and sending the bloods to the laboratory for analysis. The service tracked when these were sent.
- The service had their own laundry facilities for the gowns they offered to patients who had transvaginal ultrasound scans. Clean and dirty laundry was segregated with clean items kept in a dedicated drawer.
- The registered manager maintained a file of substances used, in line with the Control of Substances Hazardous to Health Regulations (COSHH). Staff had signed to show they had read the safety assessments and the service had commissioned a health and safety assessment in April 2019. There were no actions for the service to complete.
- Staff checked the contents of the first aid box each month, to ensure it was complete and items were in date.

Assessing and responding to patient risk

- **Staff identified and completed risk assessments for each patient attending for diagnostic tests and removed or minimised risks.**
- The service had protocols to ensure they offered patients appropriate ultrasound scans or diagnostic tests to meet their specific needs. At the time of booking, office staff checked what type of scan patients wanted and took advice from the sonographers if the request did not meet the service protocols.
- Sonographers used the Pause and Check process to ensure they carried out the right procedure on the right patient. They explored patients' medical and obstetric history, where relevant, as part of their risk

assessment. For example, for women who requested a pregnancy date scan had their estimated date of delivery, previous obstetric history and their own specific concerns checked/reviewed.

- The service had included detailed information on their website about the procedures on offer, the prices and any associated guidance. This was to help minimise the risk of patients trying to book an appointment and being advised it was not appropriate. The potential risks associated with 4D non-diagnostic scans, as advised by Public Health England's and the British Medical Ultrasound Society, were also included on the website.
- The service had a protocol for calling emergency services if a woman required an urgent transfer to the local acute hospital, for example should they have a ruptured ectopic pregnancy.
- There was also a protocol for liaising with health professionals in response to identifying possible anomalies or concerns. Whilst we were inspecting, the registered manager phoned the nearby NHS early pregnancy unit (EPU) as concerns had been identified regarding a pregnancy. They arranged for the patient to attend the EPU.
- All staff completed first aid and resuscitation training. Although the registered manager said the policy was to call 999 for an ambulance in case of cardiac arrest, this was not formalised within the policy. This meant the policy and procedure lacked guidance for staff to follow in an emergency.

Staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.**
- The service was open for patients six days a week and the three sonographers and office staff ensured that all shifts were covered, even if the service worked into evening shifts. The service did not allow lone working and there were never less than two staff on duty.
- The service did not use bank or agency staff, since the three trained sonographers could cover each other's sickness or leave between them.
- There was a message book for staff communications and the sonographers also had a shared telephone messaging system to exchange messages, updates and information.
- The service contracted two phlebotomists to take blood for non-invasive prenatal tests they attended the clinic when required. They provided the registered manager with annual evidence of their skills and training.

Records

- **Staff kept detailed records of patients' care.** Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- Patients completed admission forms, which included their name, address, date of birth and contact details. These were checked for accuracy by the sonographers before the scan. Staff set up patient records within the service's ultrasound reporting and image system, which generated reports showing, for example, images, growth charts and data and commentary. We reviewed five reports and the commentaries were clear and informative. Where an abnormality had been identified, sonographers included detailed information on the scan report for the patient to share with health professionals involved in their care.

Medicines

- The service did not store or administer medicines.

Incidents

- **The service had no recorded patient safety incidents in the past 12 months. Staff recognised incidents and near misses but did not record them in a systematic way.**
- Managers explained how they investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service had last recorded an incident over a year ago. The registered manager said they did not consistently record minor incidents, but always had internal discussions as a result of any event or incident and apologised to patients where this had been relevant. The registered manager said they would review their incident management procedure and staff training for all types of incidents.

Good

Diagnostic imaging

Are diagnostic imaging services effective?

We do not rate effective for this type of service**.**

Evidence-based care and treatment

- **The service provided care based on national guidance and evidence-based practice.**
- The sonographers updated their protocols based on those used at the local NHS trust. For example, the protocol for carrying out gastrointestinal scans. There were protocols for non-invasive prenatal tests (NIPTs) provided by the suppliers of the blood sampling packs and protocols based on best practice guidance for fetal anomaly.
- The service's ultrasound equipment was set up to operate within published guidelines for thermal exposure times and mechanical index values. Staff followed the 'As Low As Reasonably Achievable' (ALARA) principle when scanning, to minimise ultrasound exposure, and thereby promote safe, effective practice.
- There was no system for routine audit of sonographers' practices within the service, beyond the annual appraisal process. This meant there was a risk they might not be following evidence-based practices.

Nutrition and hydration

- **The service issued patients guidance on how to prepare for their scan.**
- Information on how to plan for a scan and whether women should attend with a full bladder was on the service's website. Office staff also followed this up when women made their booking.
- There were no facilities for patients to help themselves to drinks, but the service was close to a café and staff prepared people drinks if required.

Patient outcomes

- **Staff monitored the effectiveness of care.** They used the findings to make improvements and achieved good outcomes for patients.
- When sonographers identified any unusual or abnormal images that required further referral to NHS specialists, they followed up the outcomes to both offer support and to assess the accuracy of the diagnoses.
- The registered manager said their nuchal translucency scans were automatically reviewed and compared against those of other providers. A nuchal translucency scan is a screening test for Down's syndrome that involves measuring the fluid at the back of the fetus' neck (nuchal translucency) with an ultrasound scan. The registered manager would receive a notification if their assessments were not within the expected range and they had not had been advised of issues with their scans and measurements.
- The sonographers sought feedback from patients on the outcomes of their scans, and this indicated patients were satisfied with the results.

Competent staff

- **The service made sure staff were competent for their roles.** Sonographers assessed each other's work through the annual appraisal process and liaised on improving practices and procedures.
- The registered manager also worked in the same role within the nearby NHS trust, where she completed NHS appraisals and was subject to a rolling audit programme. Their most recent audit, in March 2019, showed they had passed their audit assessments.
- The sonographers undertook annual competency assessments, using a comprehensive tool involving self-assessment and peer observation. Staff had last completed these in February 2019. Although the observation assessments were undertaken by colleagues within the service, the risk that assessors might not themselves follow best practice was mitigated by the registered manager's own competency assessment within the NHS.
- The competency assessments provided opportunities for staff to discuss performance and training needs, and so was also considered as an appraisal.
- One sonographer was trained and competent to carry out testicular scans, and all patients who requested this type of scan were referred to this member of staff.

- Staff had completed training in NIPT, delivered by the NIPT provider at the service. They had attended a course entitled 'Recent advances in obstetric ultrasound' in 2017.
- The phlebotomists worked on a sessional basis at First View Imaging and had substantive contracts with the other healthcare providers. They provided the registered manager with evidence of their training and appraisals each year.
- All the patients we spoke with said they found the staff to be knowledgeable and answered their questions clearly.
- The three sonographers who worked at the service were registered with the Health and Care Professionals Council to provide diagnostic radiography.
- The office staff said they did not have appraisals, but they raised suggestions or queries with the directors and they all worked well together to improve patient experience. This meant however there was no formal system for both staff and their managers to discuss performance and personal development.

Multidisciplinary working

- **All those responsible for delivering care worked together as a team to benefit patients.** They supported each other to provide good care and communicated effectively with other agencies.
- The service had developed good links with the fetal medicine and early pregnancy units at the nearby NHS trust, and with local GPs. The service contacted the fetal medicine unit directly if they identified a patient at risk from, for example, an ectopic pregnancy. The service also had contact details for these units at other, neighbouring NHS trusts. The GP we spoke with said staff liaised well with them and other local GPs.
- The service had arrangements with the local NHS trust to plot growth measurements directly into the trust's growth charts. This approach helped flag small babies within the NHS antenatal service, and women then attended the maternity assessment unit for observation or intervention.
- We saw evidence in records that staff arranged for a patient to attend the hospital directly, following observation of an abnormal fetal heart.
- Staff said that NHS maternity staff and GPs also suggested patients attend the clinic if they wanted to have the NIPT. They explained this might be as a result of a high-risk result from a 12-week nuchal translucency scan carried out within the NHS. The nuchal translucency scan detects cardiovascular abnormalities in a fetus, a NIPT is a more accurate test for genetic and chromosomal conditions than the nuchal translucency scan. This was confirmed by the GP we spoke with.
- The local clinical commissioning group had previously given the service a fixed, short-term NHS contract to carry out specific non-obstetric ultrasound scans to provide additional capacity.
- The service also liaised effectively with the NIPT equipment providers, to ensure results were communicated promptly.

Consent and Mental Capacity Act

- **Staff supported patients to make informed decisions about their care.** They knew how to support patients to make their own decisions including those who were experiencing mental ill health.
- Staff checked what patients wanted from their appointment and gained appropriate consent. Staff explained the procedure and asked patients for verbal consent for abdominal and testicular scans and written consent for transvaginal scans.
- We spoke with patients who said they had all consented for their scan and understood the procedure and any potential risks.
- Staff explained they did not routinely share reports with patients' GPs however they would ask patients to give their GP a copy if there were findings of concern or ask their permission to send the report directly. For example, one patient told us they had been given a signed and dated report to give to their midwife, due to a particular finding associated with their pregnancy.

Good

Diagnostic imaging

Are diagnostic imaging services caring?

Good

This was the first time this service had been rated. We rated caring as **good.**

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- We spoke with ten patients and their relatives and they consistently reported that staff were polite, kind, caring and friendly. They said they were not rushed and they commented that staff introduced themselves and were professional. Comments from patients included 'lovely staff; considerate', 'really supportive and helpful' and 'excellent attitude and kind'.
- Patients said staff treated them with dignity, for example, they were given gowns to wear for internal scans. They said the layout of the clinic supported privacy and people commented they appreciated that staff locked the scanning room door during the scan, to prevent anyone entering.
- The clinic played music in the waiting area and reception, to minimise the risk of conversations being overheard.
- Patients said they rarely had to wait long, and there was sufficient space in the waiting room for their comfort.
- The service left a feedback book in the waiting room, and comments in this included, 'Thank you for your kindness, care and expertise,' 'what a wonderful experience' and 'very patient and caring'.

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress.** They understood patients' personal needs.
- Patients told us staff were reassuring and helpful and explained their scans in a way they could understand. They commented that staff were calm and described the findings thoroughly. Two people told us that staff had allayed their fears and put them at ease.
- Patients appreciated having access to information in advance from the service's website. One person said they found it informative and helped them prepare for the appointment. The service also had leaflets outlining the two types of non-invasive prenatal tests (NIPTs) they offered. Staff said they explained the differences and supported patients to make their own decision on which to choose.
- Staff described how they explained distressing findings, to help people understand the scan report and know what to do next. The service did not provide links to counselling services but recommended patients speak with the health professionals involved in their care. For example, if a woman had concerns about fetal movements, they emphasised liaising with the midwife for further guidance and reassurance.
- The service had included information on their website about the latest advice from the Public Health England on potential risks associated with ultrasound scanning in pregnancy.
- One patient told us they were grateful to have received a text message from the service, warning them of an accident on the motorway so they could allow more time for the journey to their appointment, and minimise their stress.

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients and families to understand the results of the scan and make decisions about their care and treatment.**
- Staff gave patients the reports from their scans during the appointment and explained their findings. Patients said they always received a copy of the report, with photos as appropriate, when they left the clinic. They also appreciated receiving these by email.
- Staff explained they asked women attending for antenatal scans to include these reports in their NHS

notes, to share with the health professionals involved in their care. Patients told us that staff encouraged them to maintain their NHS antenatal appointments, and to include their scan results in their notes.

- The service had leaflets outlining the two types of NIPT they offered. Staff said they explained the differences and supported patients to make their own decision on which to choose. The blood test results were returned to the clinic, and if there was a raised risk of abnormality, the sonographers contacted the patients to explain the results and advise on next steps. If there was a low risk result, office staff contacted the women with the information. The service then sent the result by email, as confirmation.
- Patients said they knew the price they were required to pay in advance and there was no confusion.
- The service advised women who wished to have an early pregnancy scan, before seven weeks, that there was a risk of an inconclusive finding, and advised on the best time in a woman's pregnancy to have a viability scan. This advice was given verbally and in writing to minimise any confusion or distress

Are diagnostic imaging services responsive?

Good

This was the first time this service had been rated. We rated responsive as **good.**

Service delivery to meet the needs of people using the service

- **The service planned and provided care in a way that met the needs of local people. It also worked with others in the wider system and local organisations to plan care.**
- The clinic was a standalone, single-story building within the grounds of an estate that had been redeveloped for private businesses. There was clear signage to find the premises and there was adjacent free parking.
- Patients could book appointments on line or over the phone. The service offered out of hours appointment times, in evenings and on Saturdays and the reception desk was always staffed until at least 4.30pm each weekday. Office staff attended evening shifts when there were booked appointments.
- The patients we spoke with said the clinic was easy to find, and provided a calm, professional environment. There was a comfortable waiting room, with magazines, children's books and toys available. The waiting room was separated from the scanning room by the reception area, which helped promote privacy. There was one toilet on the premises for patients and staff, located near the entrance and separate from reception. There was also a staff kitchen.
- As well as the main waiting room, separate from the reception area and scanning room, there was a small ante room next to the scanning room. The registered manager explained how they supported people who needed time to consider distressing news and used the ante room as an additional waiting area when appropriate.
- The First View Imaging website was clear and informative. It included guidance on the different types of services offered. The explanations were detailed and highlighted when it would be best to carry out different types of tests, and what they would show. For example, the website included sections on pregnancy scanning and medical scanning. Within pregnancy scanning the menu listed the different scans offered. For example, the information about NIPTs outlined why tests might be requested, how the test was done, waiting times for the result and what the results would mean. This information also outlined problems the tests did not detect. Information on medical scanning included details, for example, of uterine or ovarian, abdominal and testicular scans.
- The website included prices for each type of scan offered and the receptionist guided patients over the phone on the costs of different scans. Patients told us they found the website useful and they were aware of the price of the scans before they attended.
- The clinic also had information leaflets on the NIPTs in the waiting room.

Meeting people's individual needs

- **The service took account of patients' individual needs and preferences.** Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- All the patients we spoke with said the appointment times were sufficiently long for them to ask questions and gain reassurance. Staff also said they appointment times were long enough to be able to flex appointment times slightly, so they could invite women to go for a short a walk, to encourage their fetus to move and improve the scan image. People we spoke with appreciated this person-centred approach.
- The premises were on the ground floor and were accessible to people with mobility needs. The toilet was not compliant with the Disability Discrimination Act (DDA), in terms of size of the room and wheelchair accessibility. The registered manager said they recommended people who required DDA facilities to book with a specific alternative provider who they knew could accommodate their specific needs.
- Staff explained they could flex appointment times should they need to break bad news to patients, and always supported patients with arranging referrals to NHS services in these circumstances.
- The service did not have access to translation services. Staff said they encouraged patients to bring friends or relatives with them if they did not use English as their first language, or they used a telephone translation application. This is not best practice and staff recognised there was a risk with this approach.

Access and flow

- **People could access the service when they needed it and received the right care promptly. People had appointments when they wanted them and did not have to wait long for their procedure.**
- All patients we spoke with said they had appointments when they wanted them, and sometimes this was on the same day they contacted the clinic. They said they did not have to wait long on arrival at the clinic for the booked appointments, and most commented they only waited a couple of minutes.
- Office staff were available six days a week to take bookings over the phone, and patients could also book via social media.
- We heard comments from patients such as 'they fitted me in when it was convenient to me', I wanted to take my partner and I was fitted in on a Saturday' and 'when I was worried they fitted me in the same day'.
- Hospital and primary care healthcare professionals signposted patients to the service for specific diagnostic tests not available immediately through the NHS. We spoke with a GP who had signposted patients to First View Imaging, who said the service was responsive to people needs and arranged appointments at short notice.
- If patients wanted to have a NIPT, the service coordinated with their phlebotomists to arrange a mutually convenient time for them to attend the clinic.

Learning from complaints and concerns

- **It was easy for people to give feedback and raise concerns about care received.** The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff**.**
- There had been one complaint in the past year and this had been managed in line with the service's procedure. There was guidance on the service's website on how to make a complaint and the complaints process.
- The registered manager explained how they treated concerns and complaints seriously. Staff completed on-line training on complaint handling and were encouraged to resolve any concerns from patients promptly. Staff involved directors of any problems and advised them on steps taken to mitigate a serious outcome.
- The service investigated any issues raised and shared lessons learned with all staff. For example, there was learning from a complaint relating to expectations associated with an early pregnancy dating scan. As a result, the service had created a specific information sheet they gave to patients on booking (by email or verbally), advising them on what to expect from this type of scan. This was also detailed on the service's website

Good

Diagnostic imaging

- Patients we spoke with said they would feel comfortable to raise concerns with the staff if they had any.

Are diagnostic imaging services well-led?

Good

This was the first time this service had been rated. We rated it as **good.**

Leadership

- **Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff by being onsite and available.**
- The registered manager understood the challenges to quality, safety and sustainability and took steps to address and manage them. For example, they were aware of their accountability and responsibility for patient care and understood their role of registered manager.
- The registered manager and the other two directors of the service were visible and approachable which meant they were available to support staff and provide effective leadership. There was a director on site five days a week.

Vision and strategy

- **The service had a vision for what it wanted to achieve worked relevant stakeholders.**
- First View Imaging's vision was to provide a safe, timely, comprehensive service led by clinical staff who believe that they can make a difference to the patient's experience. The registered manager explained this was achieved by listening to what the patient required and meeting their expectations.

Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- Staff told us they enjoyed working at the service, and there was a friendly, supportive culture where people were happy to raise concerns or make suggestions.
- Staff said there was an open culture and they would be open with patients and their families if they made an error. They were aware of their responsibilities under the duty of candour legislation.
- The service valued staff and supported them to adapt their working arrangements to suit their personal circumstances. For example, to help a staff member return to work flexibly after maternity leave.

Governance

- **Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn. However, some of the service's policies and procedures needed review to ensure they were clear, up to date and comprehensive and this was recognised by the provider as an area for development.**
- The service had systems and processes to support the delivery of a safe and caring service, however there were some gaps. All staff had regular criminal safety checks and completed mandatory training appropriate to their role. The sonographers completed annual competency assessments. The service had good links with the local NHS trust and reviewed and updated protocols based on those used within the NHS. They had systems for recording cleaning, complaints and patient feedback. The incident management procedure was not formalised to capture minor incidents and near misses and there were no appraisals for office staff.
- Staff understood their roles and only carried out scans and procedures in line with their competencies. The service had not set up an audit process for all diagnostic practices.
- The service had team meetings approximately once a quarter, which were minuted and shared, and there

was effective communication at other times in between these meetings. We saw these were used to share guidance, for example on the needle type to use when taking blood for NIPTs. The service maintained a handover book to support effective communication between staff working part time.

- The provider's policies and procedures were held on line. The policies were not dated so it was not clear when they had last been reviewed to reflect current best practice and guidance.

Managing risks, issues and performance

- **Leaders and staff managed performance effectively. They identified and managed relevant risks and issues and identified actions to reduce their impact, however the risk management framework was not formalised. They had plans to cope with unexpected events.**
- The service identified risks associated with the environment and had annual health and safety audits. The service had public liability insurance and staff were covered by medical indemnity.
- The registered manager understood the risks relating to the premises, service delivery and business. There was evidence that risks had been identified and mitigated but these were not formally recorded within a risk management framework. For example, there was not a formalised risk management framework to help identify and manage emerging risks.
- Staff carried out cleaning and hygiene audits and there was an annual contracted health and safety audit.
- The service did not employ bank or agency staff and the staff team covered for each other's absence.

Managing information

- **The information systems were integrated and secure, however the data management policies needed to be reviewed and streamlined.**
- The clinic's electronic systems were password protected. The service used a recognised ultrasound software package which meant measurements and photographs were automatically collected into reports.
- The provider gave patients copies of their reports. For baby keepsake pictures, the software used automatically removed identifying information from the image before the photos were generated, to protect confidentiality.
- The service had not experienced any information breaches.
- The service provided patients with clear information relating to the type of scan they wanted and the costs.
- There were different information management policies for information governance, information quality, confidentiality and data protection and medical records, which meant there was a risk of confusion and inconsistency.

Engagement

- **Leaders and staff actively and openly engaged with patients, staff and other health providers. They collaborated with partner organisations to help improve services for patients.**
- The service used different methods to engage with patients to seek their views on the service. Results indicated high rates of satisfaction. First View Imaging had a social media page and there were over 100 feedback comments which were very complimentary. The service also carried out a patient survey twice a year of 20 patients, which asked questions about, for example, their confidence in staff, whether staff listened and explained things, attitude of staff, cleanliness, and comfort. The most recent results showed almost all patients responded with 'excellent' to all the questions, with one or two 'goods'. In addition, the service maintained a comments book in the waiting room, and these comments were also very positive.
- Patients also gave informal feedback directly to staff. For example, the service now aimed to book families who wanted to attend as a group at the end of a clinic session, to help maintain a calm environment. This was in response to an observation from a patient.
- The directors maintained regular links through a messaging app, so they could share information

without necessitating formal meetings. Although they held staff meetings once a quarter, staff said they made service improvement suggestions at any time, and they were encouraged to share their ideas.

- We observed the registered manager engaged promptly and effectively with NHS health staff when necessary. She explained the service had good, direct links with the local hospital and contacts with other hospitals nearby and GPs.

Learning, continuous improvement and innovation

- **All staff were committed to continually learning and improving services.**
- Staff took pride in their work and aimed to make improvements where possible. The registered manager said she shared learning from working in the NHS trust and found this useful.

Outstanding practice and areas for improvement

Outstanding practice

- Patients told us that staff went the 'extra mile'. For example, one patient told us they were grateful to have received a text message from the service, warning them of an accident on the motorway so they could allow more time for the journey to their appointment, and minimise their stress. Other patients said they were given time to go for a walk during their appointment to encourage their fetus to move in preparation for their scan.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should implement a systematic method for recording incidents and actions.
- There should be regular audits of sonographer practice, to ensure they follow best practices guidance.
- The provider should record actions taken in response to audits, such as the hand hygiene audits.
- The provider should include review dates on policies and procedures and check they are comprehensive to provide guidance for staff. For example, the safeguarding policy and the policy for emergency procedures.
- The service should have access to translation services for those patients for whom spoken English is not their first language.
- The provider should check all risks have been identified and managed, through a formalised process.
- All staff should have the opportunity for an annual appraisal.