Ultrasound Partners 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?	Not sufficient evidence to rate
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

We found areas of good practice:

- There was a system for identifying and reporting potential abuse.
- There was a system for reporting and learning from incidents.
- The staff had up to date mandatory training to ensure they were knowledgeable about best practice.
- There was personal protective equipment available for the sonographer to use.
- The equipment was clean and well maintained.
- There was a process for escalation of unexpected findings during ultrasound scans.
- There was a proactive approach to training and continued professional development.
- Women were cared for by a clinically competent and professional sonographer.
- Feedback from women was overwhelmingly positive during the inspection.
- The privacy and dignity of women was always maintained.
- Appointments were scheduled to meet the needs and demands of the women accessing the service.
- The service managed risk well and used feedback to learn and improve the service.

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

- Fire exits where not always kept clear.
- The clinic space was not accessible to all as it was situated on the first floor of a building with no lift.
- Several policies and procedures were past their review date.
- The chaperone provided by the service had not received any training for this role.

Name of signatory

Nigel Acheson

Deputy Chief Inspector of Hospitals – London and South East

Overall summary

Ultrasound Partners is operated by Ultrasound Partners Limited. The service provides diagnostic imaging (pregnancy ultrasounds) for self-referring private patients. The service has one employee who is a sonographer and also the registered manager.

We inspected this service using our comprehensive inspection methodology. As the clinic was open on different days every week we announced the inspection to the provider one week prior to the date to ensure the clinic was running. We carried out the inspection on 4 June 2019.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	Ultrasound Partners provides obstetric ultrasound scans to private patients. In the last 12 months the service has scanned 1,249 women. We rated this service as good. This is because we found the sonographer was trained, skilled and competent to provide the service. There were processes to identify and report potential abuse. The centre was clean, and all equipment was well maintained. The sonographer kept up to date with the latest clinical guidance and adjusted their practice accordingly. Patients and those close to them were overwhelmingly positive about their experience and said they were treated with compassion. We observed patients being treated with the upmost respect and having their privacy and dignity maintained.

Summary of findings

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Good

Ultrasound Partners

Services we looked at
Diagnostic imaging

Summary of this inspection

Background to Ultrasound Partners Limited

Ultrasound Partners is operated by Ultrasound Partners Limited. The service opened on 1 November 2017. It is a private clinic in Dartford, Kent providing baby ultrasound scans. The clinic primarily serves the communities of Dartford and surrounding areas. It also accepts patient referrals from outside this area.

The service has had a registered manager in post since 19 April 2017.

Our inspection team

The service was inspected by a CQC inspector. The inspection was overseen by Catherine Campbell, Head of Hospital Inspection.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. As the clinic was open on different days every week we announced the inspection to the provider one week prior to the date to ensure the clinic was running. We carried out the inspection on 4 June 2019.

Information about Ultrasound Partners Limited

The clinic is registered to provide the following regulated activity:

- Diagnostic Imaging.

During the inspection we spoke with the only member of staff employed by the service. Their role was the sonographer and the manager of the service. We spoke with three women, two relatives and reviewed three sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the services first inspection since registration with the CQC.

Activity (June 2018 to May 2019)

- In the reporting period May 2018 to June 2019 There were 1,249 scans performed at the service. They were all privately funded.

The service employed one sonographer, who was also the registered manager. A receptionist was shared with two other services that used the same building.

Track record on safety:

- No never events or clinical incidents
- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff) or E-Coli.
- The service received one formal complaint

Services provided under service level agreement:

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

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated it as **Good** because:

- The sonographer had training on how to recognise and report abuse. There was a safeguarding lead and a clear protocol to follow.
- The unit was visibly clean, and staff adhered to infection prevention and control practices in their interactions with patients.
- The sonographer had the right skills and experience to keep people safe from avoidable harm and provide the right care and treatment.
- There was a system in place to service equipment regularly and a contract to repair or replace in the event of equipment failure.
- The sonographer recognised incidents and there was a system to report and learn from them.

However:

- One of the fire exit doors was locked on the inside on the day of inspection. This meant people would not be able to leave the building by the designated fire escape in the event of an emergency.
- The clinic space was on the first floor with no lift and women were not informed of this before booking the appointment.

Are services effective?

Not sufficient evidence to rate

We do not rate effective.

- The sonographer had registered onto the Society of Radiographers voluntary register.
- The sonographer was knowledgeable about the consent process and obtained consent in line with national guidance.
- The service provided was based on the latest national guidance. Systems were in place to ensure the sonographer was alerted to the release of updated national guidelines.
- The sonographer understood their role and responsibility under the Mental Health Act 2005.

Are services caring?

Good

We rated it as **Good** because:

- All patients and relatives we spoke to were very positive about the service they had received and about the staff providing the service.

Summary of this inspection

- We observed the sonographer being compassionate, respectful and providing emotional support to all who required this.
- Patients received relevant information about their ultrasound scan and the sonographer gave patients many opportunities to ask questions. Language and terminology were adapted to ensure the patient and those with them understood what was happening.
- There were systems to receive feedback from patients who attended for a scan. Feedback in the 12 months before the inspection was overwhelmingly positive.

Are services responsive?

Good

We rated it as **Good** because:

- The service made sure there were appointments to meet the needs of patients. Appointments were available seven days a week.
- There was an opportunity to have same day appointments if the scan was urgent.
- Interpretation services were available to patients whose first language was not English.
- Pictorial leaflets were available for patients who had a learning difficulty.

Are services well-led?

Good

We rated it as **Good** because:

- The manager had the right skills and abilities to manager a service providing high quality care.
- The manager had a vision for the service and was making plans to achieve these gaols.
- Governance processes enabled the manager to monitor the quality of the service.
- The service robustly managed and used information to support its activities.
- The service used feedback from patients to learn and improve the service provided.

Good

Diagnostic imaging

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

Are diagnostic imaging services safe?

Good

We rated it as **good.**

Mandatory training

- **The sonographer had completed mandatory training in key skills.**
- During the inspection we looked at the training record of the sonographer and saw they had completed a range of mandatory training courses as part of their employment in an NHS hospital.
- Courses included, but were not limited to, fire safety, equity and diversity, infection prevention and control, information governance, basic life support and privacy and dignity.
- Training was completed in a combination of online and face to face training.

Safeguarding

- **The sonographer understood how to protect patients from abuse and the service had arrangements to work with other agencies if needed.** The sonographer had received training on how to recognise and report abuse, and they knew how to apply it.
- There were systems, processes and practices to keep patients safe from abuse. The service had a safeguarding adult's policy which was due for review in June 2022. The policy provided information about what constitutes abuse and what to do in the event of a concern. The policy did not contain information on female genital mutilation, but the sonographer told us if they identified this as a concern it would be reported.
- A flow chart showing the process to follow in the event of identifying abuse was contained within the policy and displayed in the consultation office. The flowchart included contact details for the police, local social services and a contact number for advice relating to safeguarding concerns.
- The sonographer was the safeguarding lead and had completed training on safeguarding adults' level one and two and safeguarding children level one and two. They had not raised a safeguarding alert in the 12 months prior to inspection but could describe what constituted abuse and the process for escalating a concern.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. The sonographer used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- Clinical areas visited during the inspection were visibly clean and tidy. Personal protective equipment was available and used appropriately. The service had an infection control and prevention policy and a hand hygiene policy that were due for review in June 2022.
- The abdominal ultrasound probe was cleaned with anti-sporicidal wipes after every use. We observed the sonographer decontaminating the couch and using new couch protection paper in between each patient.

Good

Diagnostic imaging

- The service had a policy for the use and decontamination of trans-vaginal scan probes. Prior to transvaginal scans the probe was decontaminated, and a sheath cover placed over the probe. We observed two trans-vaginal scans during the inspection and saw the policy for decontamination was followed each time.
- During the inspection the sonographer always cleaned their hands according to the World Health Organisation five moments of hand hygiene. Records showed a colleague from the other service within the building watched the sonographers hand washing technique monthly to make sure they were correctly following hand washing practice. Alcohol-based hand gel was available throughout the clinic and we saw the sonographer using this regularly during the inspection.
- The privacy curtain in the clinical room was changed once a year or more often if it became contaminated. Records showed the curtain had last been changed six months ago. This was in line with the service policy and manufacturer's guidance.
- The service had domestic taps at the handwashing sink which did not meet the standard required by Health Building Note 00:03 Clinical and clinical support spaces as they were not 'hands free' or lever operated. Taps should be lever or sensor operated as this means they can be easy to turn on and off without contaminating the hands.

Environment and equipment

- **The service had suitable equipment and looked after it well, however the premises were not accessible to all and unsuitable for the service.**
- The service was in a two-storey building that was shared with two other services. A shared receptionist was on the ground floor.
- Fire exits where clearly signposted. However, the rear fire exit was locked during the inspection. The sonographer explained this was to prevent the door opening in the wind. This meant in the event of a fire the evacuation would be delayed by the locked door.
- Fire training formed part of the mandatory training programme. Records showed the fire alarm and fire extinguishers were maintained on a regular basis.
- The scanning room was on the first floor of the building and there was no lift. Women attending the service with another child in a pushchair needed help to carry the pushchair to the consultation room which could pose a risk in pregnancy.
- There was one toilet available on the ground floor, but this could not accommodate people with a disability.
- The ultrasound machine was maintained every six months and the service kept a log of this. Records confirmed all equipment had a current repair contract in the event of equipment failure.
- The scanning room had good lighting which could be dimmed to allow ultrasound images to be clearly viewed. A large screen on the wall showed the scan images to the patient and those with her during the scan.
- There was a reception and waiting area for patients and those with them on the ground floor of the building.
- We saw well stocked clinic store cupboards with equipment needed for ultrasound such as contact gel and paper towels. The sonographer told us they had enough equipment and supplies to provide a high standard service.
- The service did not have access to resuscitation equipment, but the sonographer was trained in basic life support in line with a service of this type. A first aid kit and a body fluid spillage kit were available.
- Clinical and non-clinical waste was handled and disposed of in a way that kept people safe. The service used a colour coded system to separate and dispose of waste. Waste was stored in secure, colour coded bins which both met the required standard of health technical memorandum 07/01 management and disposal of healthcare waste. Records showed the clinical and non-clinical waste was collected by an approved contractor on a weekly basis.

Assessing and responding to patient risk

- **The sonographer removed or minimised risks for patients. The sonographer identified and quickly acted upon patients at risk of deterioration.**

Good

Diagnostic imaging

- The sonographer had clear processes to escalate unexpected or significant findings at the examination. A poster showing the actions to take and the key contacts within the NHS was displayed in the office of the service.
- During the inspection we heard the sonographer advising women to attend their NHS scans as part of their maternity pathway.

Staffing

- **The sonographer had the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- The service was led by the registered manager who was also a sonographer. Their time was shared between clinical practice and non-clinical responsibility.
- The service shared a receptionist with the other providers within the building.
- There were no medical staff employed by the service however the service had access to a radiologist for clinical advice and to review scans showing unexpected findings.

Records/Quality of records

- **The sonographer kept records of patients' care and treatment.** Records were clear, up-to-date and easily available. During the inspection we looked at three records which were completed according to the service policy
- Patients self-referred and booked their scan via an online form. In line with similar services minimal information was recorded at the appointment. This included name, email address, contact details, date of birth, date of last menstrual period and date of positive pregnancy test.
- Electronic records were stored on a password protected computer with another password needed to access the record application. The computer was locked by password when not in use. No patient information was transferred electronically.

Medicines

- This service did not use any medicines.

Incidents/Incident reporting, learning and improvement

- **The service managed patient safety incidents well.**
- The service had an incident policy which was due for review in June 2022. The policy outlined the various incidents that would result in harm and had a form that could be used to report an incident.
- The sonographer could clearly describe what would constitute an incident or a never event. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systematic protective barriers, are available at national level, and should have been implemented by all healthcare providers.
- The service had not reported an incident or never event in the 12 months prior to inspection.

Are diagnostic imaging services effective?

Not sufficient evidence to rate

Evidence based care.

- **The service provided care and treatment based on national guidance and evidence-based practice.** The sonographer had access to up to date procedures and clinical guidelines, but some policies were out of date.
- We reviewed policies, procedures and guidelines implemented within the service. These were based on guidelines produced by the Royal College of Radiologists, British Medical Ultrasound Society and the National Institute for Health and Care Excellence. Electronic alerts were set up to notify the sonographer of policy and guideline updates.
- Policies, procedures and guidelines were accessible for the sonographer to refer to and available in electronic or paper format. During the inspection we noted some policies were out of date and some policies had no review date. The policies included

consent, hand hygiene, fire safety, data quality and equity and diversity policy. This was highlighted to the sonographer who acted promptly to update the policies immediately after the inspection.

Nutrition and hydration

- The service did not provide food for patients as they were only attending for a short time. Patients had access to water whilst waiting for their scan.

Pain relief

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

Patient outcomes

- **The sonographer monitored the effectiveness of care and treatment and used the findings to improve them.**
- The standard of scan reporting was monitored by a radiologist who visited the service every six months and reviewed three patient pathways including reported ultrasound scans.
- The service used the British Medical Ultrasound Society peer review audit tool patient pathway to score the accuracy of the ultrasound scan reports. During the peer review three aspects of the examination were reviewed. The clinical questions, the images and the report and advice given to the patient. Each was categorised into good, acceptable and poor. Any discrepancies, if identified, would be discussed with the sonographer at the time of the review.
- Records showed in the 12 months before inspection peer review had been done in accordance with the service protocol. All areas of the scan process were scored as good.

Competent staff

- **The service made sure staff were competent for their roles.**
- Sonographers do not have a protected title and therefore do not need to be registered with the Healthcare Professionals Council. However, the sonographer at the service had a voluntary registration with the Society of Radiographers.
- The service employed one sonographer and therefore did not perform any staff appraisals. The sonographer had received an appraisal with their NHS employment as a sonographer in 2017.

Multidisciplinary working

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

Seven-Day services

- **The service offered a range of flexible appointments.**
- Women could access the service at a time that was convenient to them. The service offered appointments all day at the weekend and during the week by arrangement only.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **The sonographer understood how and when to assess whether a patient had the capacity to make decisions about their care. The sonographer understood their role and responsibility under the Mental Health Act 1983 and the Mental Capacity Act 2005.**
- We saw that the sonographer obtained and recorded verbal consent from patients before undertaking the scan. The sonographer described the importance of gaining consent from the patient before undertaking any procedure.

Good

Diagnostic imaging

- The service had a consent to examination policy. The policy had a review date of April 2019 and had not been updated. This was pointed out during the inspection and the sonographer acted promptly and provided the inspector with an updated policy following the inspection. The policy referenced the Mental Capacity Act 2005. The sonographer was up to date with mandatory training on the Mental Capacity Act 2005.
- The sonographer showed an understanding of mental capacity and what actions to take if they had concerns about a patient's capacity. They knew how to support patients experiencing mental health problems and those who lacked capacity to make decisions about their care.

Are diagnostic imaging services caring?

Good

Compassionate care

- **The sonographer cared for patients with compassion.** Feedback from patients confirmed that they had been treated well and with kindness.
- We observed the sonographer interacting positively with patients and those attending the appointment with them. Patients were spoken to with sensitivity and appropriately depending on individual needs. During the inspection we spoke to three patients, two relatives and looked at online feedback about the service.
- Patient comments included
  - "Very kind and nice service. I would definitely go again!",
    "Very detailed ultrasound and explained everything thoroughly. Highly recommended"
- The sonographer was very friendly, professional and put patients at ease. They introduced themselves by name and explained each stage of the procedure during the appointment.
- The sonographer provided the patient with a paper skirt to make sure their dignity was maintained. Patients could undress and dress in private before the scan in the scan room.
- Posters informed patients that a chaperone was available for intimate scans. Most patients had a relative accompanying them and declined the chaperone. The female receptionist, who worked at the premises, acted as a chaperone when needed but had not received training for this role. On a Sunday the sonographer was the only member of staff on duty and told us they would not perform an intimate scan when working alone.

Emotional support

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

Understanding and involvement of patients and those close to them

- **The sonographer involved patients and those close to them in decisions about their care and treatment.**
- Patients and those close the them told us they had received information in a way they understood. Patients were encouraged to contact the service with any concerns.
- Leaflets explaining each scan were available for patients to download from the services website at the time of booking the scan. The sonographer gave a detailed explanation of the scan and allowed time for patients to ask questions before the scan.
- Patients told us they had enough information to understand what was happening during the scan.

Good

Diagnostic imaging

- Relatives and friends who accompanied the patient were also encouraged to ask questions about the ultrasound scan if they needed something clarifying.

Are diagnostic imaging services responsive?

Good

Service delivery to meet the needs of local people

- **The service planned and provided services in a way that met the needs of local peopl**e by providing reassurance in early pregnancy and identifying foetal abnormality earlier than routine scanning that complimented NHS services.
- There were plans to widen access to ultrasound scanning for the local population. There was a plan to expand and offer non-obstetric ultrasound scans and initial contact had been made with local NHS clinical commissioning groups to discuss this next step. The manager was also considering expanding private services to include non-invasive prenatal testing.
- Patients could park in a nearby public car park. The service was easily available by public transport and was within walking distance of the railway station. A location map of the clinic could be accessed via the services website.

Meeting people's individual needs

- **The service took account of patients' individual needs.**
- The clinic had no facilities to accommodate patients who used a wheelchair or had a mobility issue as the clinic was on the first floor and the building did not have a lift. There was one toilet on the ground floor which was accessed by going down one step. It had not been adapted for a wheel chair user or a person with disabilities. This was not made clear when booking a scan.
- The sonographer was aware of the individual needs of those living with a disability. Due to the nature of the service provided they had never had a patient attend who had complex medical needs.
- The scanning couch could accommodate a bariatric patient of up to 240 kilos.
- A telephone interpretation service was available for patients who did not speak English.
- An easy to read leaflet with pictorial information was available, within the clinic, for patients who had a learning difficulty.

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 good practice.
- The service matched the service delivery to the needs of their patients. Ultrasound scan appointments were available on the website for patients to book directly. If a convenient appointment was not available, the patient could contact the service to find a more suitable date and time. The service kept two appointment slots free for urgent appointments each day. This meant it was sometimes possible to book a scan on the same day.
- Patients could directly book an appointment for an ultrasound scan by using the services online booking form. On arrival they booked in with the receptionist and sat in the waiting room before being called up for their scan.
- Records showed that patients were provided with a written report of the results of the ultrasound scan and two photos of the baby.
- An electronic system was used to monitor the number of patients who did not attend for their scan. In the 12 months prior to the scan 15 patients did not turn up for their scan. These were all early pregnancy scans and it was assumed they were no longer pregnant although there was no formal follow up to confirm the reason for not attending.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results.**

Good

Diagnostic imaging

- There were processes to ensure patients and their relatives could make a complaint or raise concerns and were aware how to do so.
- There was a complaints policy which was due for review in June 2020. This provided the sonographer with detailed actions to take if a patient or their relative wished to make a complaint.
- The service had received one written complaint in the 12 months prior to inspection. We saw the complaint had been dealt with in line with the services policy.
- The sonographer repeatedly asked patients if they were happy with the service and the ultrasound they had received. All efforts were made to resolve issues before the patient left the clinic.

Are diagnostic imaging services well-led?

Good

Leadership

- **The manager in the service had the right skills and abilities to run a service providing high-quality sustainable care.**
- The manager maintained their skills through continuing clinical practice. The registered manager was also a sonographer and was subject to clinical practice development through their NHS practice.
- Records showed the registered manager had almost completed a six-month leadership development programme. This was designed by the NHS Leadership Academy Group and developed knowledge and skills in leadership and management.
- In the inspection feedback we told the registered manager of several policies that were out of date. They responded positively and provided us with updated policies within days of completing the inspection. This demonstrated an open culture of learning and improvement.

Vision and strategy

- **The service had a vision for what it wanted to achieve and workable plans to turn it into action.**
- Although there was no documented vision for the service the manager described a clear vision of a service that complimented the NHS antenatal programme. The manager told us about plans to expand the service and widen access for local people.

Governance

- **The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.**
- The registered manager had overall responsibility for governance and quality monitoring.
- The service used an external peer review to audit the quality of the ultrasound reports. Records showed in the last 12 months two sets of patient pathway peer reviews had occurred as per the provider protocol.
- The sonographer had the professional qualifications required by the role. During the inspection we looked at their identification, professional qualifications and disclosure and barring service certificate.
- Details of public indemnity insurance for this service was displayed in the consultation office.
- Feedback from patients was used to improve the quality of the service. For example, following patient feedback; patients who were less than six weeks pregnant were told it was normal not to be able to see a baby's heart beat during the scan. This reduced the anxiety of women who were booked in for early scans.

Management of risk, issues and performance

- **The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- The service had arrangements for identifying and recording risks. The risk register identified what the risk was, who might be harmed, and action taken. There was a review date for the risks identified in place. The risks were reviewed every two years.
- Risks identified included slips and trips, equipment failure and infection and prevention control.

Information management

Good

Diagnostic imaging

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

Engagement

- **The service engaged well with patients, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.**
- The service gathered women's views and experiences to improve the service provision. Feedback could be gathered through comment cards. The majority was gathered through social media feedback where women could make comments about their experience and provide a rating.

Learning, continuous improvement and innovation

- **The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.**
- The sonographer provided examples of improvement or changes they had made to processes based on patient feedback. This included increasing the length of time for each appointment.
- They had participated in national clinical research into developments in fetal medicine.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure the fire exits are secure and able to be used in the event of a fire.
- The provider should ensure clinical taps are available for effective hand washing.
- The provider should ensure women are aware the clinic space was not accessible to all at the point of booking the scan. This will allow the women to make an informed decision about being able to access the clinic at the time of booking the scan.
- The provider should consider implementing systems to review internal policies and confirm they are up to date.

  The provider should provide staff used as a chaperone with appropriate training.