Ultrasound Direct London

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

Overall summary

Ultrasound Direct London is operated by A1F1 Ltd and was a franchise of Ultrasound Direct Limited. The service provides ultrasound imaging services from one registered location and seven satellite locations.

The service provides ultrasound imaging and diagnostics for patients aged over 16 years. We inspected diagnostic imaging services.

We inspected this service using our comprehensive inspection methodology. We carried out the and unannounced visit to the service on 12 and 13 March 2020.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

We have provided guidance for services that we rate and do not rate.

Services we rate

We rated it as **Good** overall because:

- The service had enough staff to care for patients and keep them safe and had flexibility built into the system to allow for extra capacity. All staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment and offered them something to drink while waiting. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients to plan services and staff were committed to improving services continually.

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. Details are at the end of the report.

Nigel Acheson

Deputy Chief Inspector

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	Ultrasound Direct London provided an ultrasound scanning and screening service for privately paying patients over the age of 16. We rated this service as good because it was good for safe, caring, responsive and well-led. We do not routinely rate effective for this type of service.

Summary of findings

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Summary of this inspection

Background to Ultrasound Direct London

Ultrasound Direct London is operated by A1F1 Ltd. The service was originally registered in 2012 under a different name and at a different location but provided the same services. The current location was registered with Care Quality Commission (CQC) in 2019. It is a private ultrasound provider based in Croydon, Surrey. The service also operates from seven satellite locations across London. The service serves communities across London. It also accepts patient referrals from outside this area.

The service has had a registered manager in post since 2019, this manager also managed the previously registered service. We inspected service in 2013 under our previous methodology and found there to be no breaches of regulations.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector and one other CQC inspector. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital inspection.

Information about Ultrasound Direct London

Ultrasound Direct London is a franchise company which provides private diagnostic ultrasound and screening services with results on the same day. The service had one registered location, in Croydon, and seven satellite units across London and was registered to provide the following regulated activities:

- Diagnostic and screening procedures.

Ultrasound and screening services were available for patients who self-referred. The service offered a range of pregnancy scans and packages and non-invasive prenatal testing (NIPT), which involved taking a blood sample and testing it to determine the risk of a foetus having a genetic abnormality. The service also offered male and female health screening scans and various other diagnostic services.

During the inspection, we visited the registered location based in Croydon and two satellites to ensure standards were maintained across the satellite premises. We spoke with six members of staff including sonographers and clinic assistants. We spoke with eight patients and five relatives.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The service had not been inspected since amending its registration in 2019.

The service employed were three full time sonographers and 11 part time or sessional sonographers and clinical assistants to support them.

Track record on safety (1 January to 31 December 2019)

- No never events
- Clinical incidents – None categorised as severe harm and no serious injuries
- No healthcare acquired infections
- There had been no transfers to other health care providers
- There had been formal 46 complaints

Services provided at the hospital under service level agreement:

- Waste management and removal
- Blood sample analysis

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 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 the service worked well with other agencies to do so. Staff had 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 were trained to use equipment. Staff managed clinical waste well.
- Staff assessed patient's risks informally and advised them how best to act. Staff communicated with other services, with explicit patient consent, to hand over care to other organisations.
- 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. Managers adjusted staffing levels to meet patient needs.
- 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 managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Are services effective?

We do not rate effective for this type of service.

- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff understood how to protect the rights of patients' subject to the Mental Health Act 1983.

Summary of this inspection

- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Services were available seven days a week to support timely patient care.
- Staff gave patients advice to support their health.
- Staff supported patients to make informed decisions about their care. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Are services caring?

Good

We rated caring as Good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs
- Staff supported and involved patients and those close to them to understand their scan results and to make decisions about which scans to have.

Are services responsive?

Good

We rated responsive as Good because:

- The service planned and provided care in a way that met the needs of local people and the communities served.
- 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 it and received the right care promptly.
- 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.

Are services well-led?

Good

We rated Well-led as Good because:

Summary of this inspection

- Leaders had the, 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.
- 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.
- The service had clear aims for what it wanted to achieve.
- Leaders operated effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- The service collected reliable data and analysed it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients to plan and manage services.
- All staff were committed to continually learning and improving services.

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

We previously did not have the authority to rate this service. However, on this inspection we rated it as **Good.**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

All staff we spoke with were compliant with their mandatory training. Staff told us it was useful and helped them carry out their jobs safely. Mandatory training requirements were different for clinic assistants and sonographers.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers were aware of when staff mandatory training needed updating. The new regional manager told us the way this was managed was going to change in the future in order to make it a simpler system. Every staff member we asked knew their compliance with mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training included, but was not limited to, health and safety training, basic life support, infection control, control of substances hazardous to health and fire training. All staff told us they found the training to be informative and supported them to care for patient's safely.

Sonographers were trained in carrying out certain administrative duties to ensure they could also help to provide cover for any administrative staff sickness or annual leave.

Following the inspection we requested the current mandatory training figures for the service, we were sent these and they demonstrated that all staff were compliant with their expected mandatory training.

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 abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Staff were trained to different levels, depending on their role. All sonographers and clinical assistants were compliant with level two safeguarding training for both children and adults. There were named leads for adult and child safeguarding who were trained to level three. We were told that if a case was particularly complex ultrasound direct head office had staff trained to level four to support clinical staff.

The child safeguarding training did not cover female genital mutilation (FGM) in depth, this had been recognised by the regional manager and full-time sonographers were being enrolled on a course specifically to raise awareness of this. The regional manager had already attended the course, and we were sent their certificate of attendance. Most of the sessional sonographers also worked in the NHS and as a result their safeguarding training already contained education about FGM.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Both clinic assistants and sonographers were able to give comprehensive lists of what may cause them to consider the need to make a safeguarding referral, these included both signs of physical abuse and more subtle signs of potential abuse. Staff told us about a recent safeguarding referral that had been made to the local authority and how the service had worked to ensure this went to the correct place.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had named safeguarding leads for both children and adults. The regional manager was able to be contacted, if either of the safeguarding leads were not available. The service had recently needed to make a safeguarding referral and told us this had not gone as smoothly as they would have liked. This led to them creating local lists of the safeguarding authorities and contacts within them, these were available in all the clinics we visited.

Staff followed safe procedures for children visiting the service. The service did not image children under the age of 16, but patients were permitted to bring younger children with them for appointments. Staff told us they did not allow children to be left in the waiting room unaccompanied.

Staff also told us if a young 16-year-old accessed the service with a pregnancy that would mean she had become pregnant before turning 16 and they would make a safeguarding referral as she would have been below the legal age for sexual consent.

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.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Scanning rooms all had wipe clean couches and were covered with disposable paper for each patient. All scanning couches we saw were intact and had no cracks in the coating.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The service kept daily records of cleaning that had been completed. We saw that these were detailed and tailored to the equipment in each room. There were separate cleaning records for waiting rooms and scan rooms and again separate records for the ultrasound machine itself and the trolley which stored the blood taking equipment. In all clinics we visited the cleaning records were completed for all the days the clinic was open.

There were separate cleaning records for the probes used for internal ultrasounds. We observed that cleaning of these probes was completed in line with the infection control policy. The clinics also had a supply of both latex and non-latex condoms for use on the internal probes.

All scan rooms had blood spill kits, for the safe cleaning of blood spills. These were all in date and sealed. Some scan rooms were carpeted, rather than having easily cleaned laminate flooring. We asked staff what would happen if blood was being taken and some was spilt and they explained that there was wipeable plastic covering on the floor, underneath the scanning couch and that bloods would only be taken over this, therefore minimising the risk of blood being spilt on carpet.

The service was in the process of putting portable sinks in scan rooms, some already had them. For those scan rooms without sinks we observed sonographers used the bathroom sinks nearby to ensure their hands were cleaned. This ensured correct hand hygiene was being carried out, although it was not always possible in the scan room. We observed there was sanitising gel available in each scan room.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff always wore PPE correct for the scan they were undertaking. This followed the infection control principles laid out in the company infection control and decontamination policy.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw there was an infection control and decontamination policy that was in date set out how all equipment was to be cleaned and how frequently it should be cleaned. The policy explained the differed between decontamination, disinfection and cleaning and followed best practice guidance and had separate guidance for cleaning

depending on how invasive the scan was. While on inspection we saw all staff adhered to the principles set out in the policy, including remaining bare below the elbow.

We found a non-disposable tourniquet in one of the scan rooms. We pointed this out to the sonographer, who disposed of it immediately. It was explained to us that this had been part of a medical set pack and it was not normal practice to have reusable tourniquets on site. Tourniquets are the bands put around patient's arms when bloods are taken, best practice is to use disposable tourniquets for effective infection control, the service did have a supply of disposable tourniquets.

The service completed infection control audits and handwashing audits. In addition to this the service produced an infection control newsletter that we were sent following inspection, this collated concerns raised by staff and reminded them of basic infection control principles. It also described in depth a particular bacteria and the measures that could be taken to reduce spread.

There were no healthcare acquired infections associated with the service in the reporting period.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment. Staff managed clinical waste well.

The design of the environment followed national guidance. Scan rooms had flooring that could be cleaned easily under the scan couch. At the City clinic we found the scan rooms were carpeted, however around the couch and near the ultrasound machine there was a plastic cover over the carpet, meaning it could be easily and effectively cleaned should there be anything spilt on it.

All scan rooms we inspected had a large television screen directly opposite the couch, that was linked to the display of the ultrasound machine. This allowed patients to visualise exactly what the sonographers were doing without having to twist their necks to see the screen. This also meant sonographers could move the ultrasound machine to a position that suited them, rather than making the screen accessible for patients and their relatives. This meant sonographers were at a lower risk of long term injury from constantly twisting their backs.

The service did not have any specialist moving and handling equipment. Staff told us this was not necessary as if there was a patient with mobility issues sonographers would scan them in their wheelchair, to reduce the risk of injury in transferring to the couch.

Staff carried out safety checks of specialist equipment. Ultrasound machines had weekly quality checks carried out, we saw the logs were complete. There was also a contract with the manufacturer that meant all the machines had an annual service.

The service had suitable facilities to meet the needs of patients' families. Clinics all had comfortable waiting rooms, with plenty of seating. In all scan rooms there were sofas for relatives or carers to sit while scans were taking place.

The service had enough suitable equipment to help them to safely care for patients. There were stock cupboard checks to ensure all stock was in date. While on inspection we found no stock out of date, however, in the Wimbledon clinic we found stock stored on the floor and not on shelves. We were told by the manager that this was not normal practice but was because the clinic had ordered extra sanitiser and soap due to the COVID-19 pandemic they were keeping it in the box on the floor temporarily.

Staff disposed of clinical waste safely. We observed staff using the correct bins to dispose of clinic waste and domestic waste. We were told by the regional manager that clinic assistants would arrange for clinical waste to be collected by an external contractor. The service had recently changed their clinical waste collection contract and was auditing how quickly the external contractor responded to their request for collection as previously this had been raised by the clinic assistants as a problem.

The service had clear fire evacuation procedures and all fire extinguishers we saw were in date with their maintenance checks.

Assessing and responding to patient risk

Staff assessed patient's risks informally and advised them how best to act. Staff communicated with other services, with explicit patient consent, to hand over care to other organisations.

Staff were trained to respond promptly to a sudden deterioration in a patient's health. All staff working for the service were required to complete basic life support training. Staff we spoke with confirmed they had received the training and were confident to administer basic life support until paramedics arrived. All staff were clear that in an emergency they would call an ambulance as the service did not provide any emergency equipment on site.

Staff informally assessed each patient upon arrival and directed them to appropriate services when required. Sonographers and clinic assistants checked why patients had booked scans, in particular pregnancy related scans. If a patient was experiencing a potential miscarriage staff would direct them to the nearest pregnancy unit. We were told, on occasion, patients chose to have a private scan as this could be fitted in more quickly than an NHS scan, sonographers carried these out to alleviate the anxiety for the patient but, would make it clear they could only perform a scan and the service would try and contact the local hospital following it.

We were also told that the screening scans that were carried out also occasionally found abnormalities and staff would refer patients back to their GP with the information for onward referrals. All patients received a copy of their scan and the scan report to explain the risk to the GP. It was possible, with patient consent, for these to be sent directly to other health care professionals.

Staff knew about and dealt with any specific risk issues. Some sonographers carried out non- invasive prenatal test (NIPT) scans, which included taking a blood sample. We were told that this would always be carried out on the scan couch, to alleviate the risk of the patient fainting and falling and hurting themselves

Staff shared key information to keep patients safe when handing over their care to others. All patients received an electronic copy of their scan and report to share with other health care professionals. The service also sent scans and reports to health care professionals directly, with explicit patient consent to do so, if care needed to be escalated.

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. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough staff to keep patients safe. The service employed three full time sonographers and 11 sessional sonographers on zero-hour contracts. The full-time sonographers worked across clinics as required and the sessional sonographers told the service their availability three months in advance so extra clinics could be opened, as required by patient demand. For each clinic that ran there was also a clinical assistant scheduled, the clinical assistant manned the reception desk, supported the sonographer as required and worked as a chaperone, when patients requested.

The manager could adjust staffing levels according to the needs of patients. The number of sessional sonographers gave the service the flexibility it needed to adjust staffing needs to patient requirements. The sessional sonographers could be booked in advance to cover a full list or provide sickness cover.

The service had low vacancy rates for the reporting period. The service had a low vacancy rate, they had met the planned number of sonographers and were awaiting only one member of the non-clinical team post to be filled.

The service had high staff turnover rates. In the reporting period two out of the three sonographers they employed left the service and seven members of the non-clinical team left the service. Managers told us this was partly due to sessional staff moving freely, as they were not contracted to provide any hours they could leave without providing notice. We were also told that there had been a member of staff who had been asked to leave the service as they did not meet their standards. Due to the small number of staff employed by the service this has made the turnover rate look particularly high.

The service had low sickness rates. Sessional staff had a 5% sickness rate and employed staff had a 7% sickness rate.

The service did not use bank or agency staff. The service had a pool of sessional staff who were employed by ultrasound direct on zero-hour contracts, these staff were able to cover whole or part of busy lists and ensured there was flexibility in the bookings system. This sessional staff pool meant the service never used bank or agency staff and had full employment and training records for all staff in their organisation.

The service followed recruitment policies that included clinical staff having an enhance Disclosure and Barring Services (DBS) check, obtaining references and completing interviews. This gave the services the assurances they were employing suitable staff.

Records

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.

Patient notes were comprehensive, and all staff could access them easily. All patient records were held electronically on a 'cloud based' record system. This meant patient records were always available to sonographers, even if patients had previously been scanned at a different satellite. Patients received electronic copies of their reports and scans.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff told us if a patient's care was transferred back to the NHS, or to another independent provider they were able to send the electronic records immediately, with the written consent of the patient. We were told this was not often required. Following the appointment patients were sent links electronically to the images and scan report and were able to share this information with their new healthcare professionals if they wanted.

Records were stored securely. All records were electronic and password protected. We observed that all computers, and the ultrasound machine were left locked when not in use therefore protecting patient's confidentiality. There was also extra confidentiality afforded to patient's as sonographers had different access to clinical assistants. This meant that clinical assistants could only see certain, necessary, parts of patient records. They were not able to access image reports, as this was not deemed necessary for their job role. This meant within the service there were security measures built into the records to ensure confidentiality was upheld for patients.

Medicines

The service did not prescribe or administer any medicines.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff we spoke with were clear about what incidents needed reporting and were clear about how to report incidents. They were also clear about who to escalate reports to. In addition to the electronic reporting system there was a written first aid log, to be filled out if a patient or staff member sustained an injury.

Staff knew how to report serious incidents clearly and in line with service policy. In the reporting period there had been no never events or serious incidents. There was an overarching, in date, clinical incident reporting policy provided by the ultrasound direct head office. This laid out the steps staff were to take following an incident, including who to report to and when to report the information. This policy did not include information about duty of candour following an incident, however when we were on site we saw posters in all clinical areas reminding staff about their responsibilities under duty of candour. Staff were able to explain what was in the policy when we asked them.

Staff understood the duty of candour. Staff were able to explain what their responsibilities were under the duty of candour principles and were clear about how they would be open and honest with patients, if necessary. The service had a named member of staff to be a duty of candour representative, this meant if staff had a question they had a named point of contact.

Good

Diagnostic imaging

Managers debriefed and supported staff after incidents, when required. There had not been any serious incidents in the reporting period, however managers gave us an example of how they supported staff following an upsetting incident that had happened. This was then followed up at the most recent staff meeting, to make all sonographers aware of what had happened and how to respond should it happen again.

Staff received feedback from investigation of incidents. Staff told us they always heard back from their managers when they reported an incident. This was then also shared with all staff, if necessary, via email or at a staff meeting. For example, clinical assistants reported that the previous clinical waste collection company was taking a long time to pick up waste. The managers discussed this with them and changed company.

Staff met to discuss the feedback and look at improvements to patient care. There was a staff meeting that was held every other month. This was scheduled on different days and at different times of the day each time to try and ensure all staff could attend at least one. These meetings were also made available to dial into, for sonographers who could not attend in person and the meeting minutes were shared following the meeting.

In the reporting period (January 2019 to December 2019) the service reported no never events and no serious incidents.

Managers shared learning with their staff about never events that happened elsewhere. We were told the service heard about any serious incidents, and learning from these, that had happened in the wider ultrasound direct brand via monthly newsletters. Any applicable learning was shared with staff working for the service.

Are diagnostic imaging services effective?

We do not rate effective for this type of service.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff understood how to protect the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver care according to best practice and national guidance. Policies followed National Institute for Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG) guidelines. All policies contained referencing, meaning it was clear that they were using up to date guidance. Policies were held by the wider Ultrasound Direct brand and they amended them as and when new information was added to their advice. This was then shared with the service. All staff had to log onto their electronic profiles to actively confirm they had read policies and protocols applicable for their role.

While on inspection the service was offering printed RCOG guidelines to pregnant women about the COVID-19 virus. The service had also changed their cleaning policies in line with guidance, demonstrating they were responsive to changes in national guidance.

Staff were clear about what their role would be if they needed to care for a patient subject to the Mental Health Act. However, told us they could not recall caring for a patient who was subject to formal Mental Health Act restrictions.

All scan rooms had Society of Radiographers ‘pause and check’ posters on the walls to remind staff of the checks that needed to be completed before starting a scan. We observed that this guidance was always followed and sonographers routinely confirmed patient ID, contact details and which scan they had booked in for and why before starting the scan.

Nutrition and hydration

The service worked on an outpatient basis and did not offer any nutrition for patients, in all clinics there was water offered in the waiting room.

Pain relief

The service did not offer medicine for pain relief. However, if patients were uncomfortable during their scan staff would adjust their position or offer more cushions to make them comfortable. We observed sonographers frequently checking throughout scans that patients were comfortable and able to tolerate the pressure being used.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Managers and staff carried out a programme of repeated audits to check improvement over time. The service undertook peer review auditing of image quality and report writing in line with British medical ultrasound (BMUS) recommendations. The results of this audit were used to monitor sonographer performance and to ensure reports were thorough and easily understood by patients.

The service also performed an internal communications audit to ensure all staff were communicating with patients in a clear and friendly manner. This audit was being looked at by the new regional manager as they felt it could be improved upon. The emphasis of the new audit process was going to be ensuring that patients understood and took home the key messages they needed to from appointments.

Managers used information from the audits to improve care. The results of the above audits were used to inform where staff may need extra training or coaching. If a member of staff was not achieving as would be expected they would be shadowed for a period of time and coached in their skills until their performance improved.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Sonographers using the ultrasound equipment were trained to do so and were radiographers by background, with a Health Care Professions Council (HCPC) registration, or they were registered nurses or midwives, with a Nursing and Midwifery Council (NMC) registration or international equivalent. All staff had undergone further training since their initial radiographer, nurse or midwifery training to become a sonographer. The service held proof of this training.

Sonographers told the service which scans they were competent to carry out and this was then embedded into the booking system. For example, if a sonographer was not trained to carry out abdominal screening then patients could not book into sessions that were assigned to be run by them. We were told by sonographers they had never been pressured to work outside the boundaries of their clinical knowledge and expertise. We observed sonographers asking patients to speak with their midwives if they were asking questions that were outside of their scope of practice.

Clinical assistants underwent training to ensure they were effectively chaperoning appointments, when a chaperone was required.

Managers gave all new staff a full induction tailored to their role before they started work. There were competency packs for both sonographers and clinical assistants. These covered both the practicalities of working for the service and more specific competencies to support their job roles.

Managers supported staff to develop through yearly, constructive appraisals of their work. Yearly appraisals were completed using the centralised appraisal form. This meant the appraisals followed a structured format and were consistent. The form gave space for employees to reflect on their past year and set development targets for the coming year. While on inspection 100% of staff had an up to date appraisal and staff told us they found them useful.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff meetings were scheduled every other month and were booked on different days at different times to ensure as many staff could attend as possible. If the regional manager knew a member of staff could not attend, they would approach them before the meeting to ask if they had anything they would like discussed. The meeting minutes were circulated to staff following the meeting.

Managers made sure staff received any specialist training for their role. Most of the sessional sonographers also worked for the NHS and therefore their training needs were covered in that employment. For staff employed solely by the service they were offered training courses, such as advanced communication courses to ensure they were delivering news in a way that could be understood by patients.

Multidisciplinary working

Good

Diagnostic imaging

Staff contacted other organisations, with patient consent, to refer patients onto clinics, where necessary, following a scan.

We saw clinic assistants and sonographers worked well together to ensure patient care was smooth.

Seven-day services

Services were available seven days a week to support timely patient care.

At least one clinic was open each day of the week, this meant a patient could always get an appointment the next day, but they may have to travel a little further then their local clinic.

The phone lines were available for patients to call seven days a week. In the week the lines were open eight AM to eight PM and on the weekends were open nine AM to five PM, the telephone were operated by the clinical assistants. The service opened clinics on all bank holidays, with the exception of Christmas day.

Health promotion

Staff gave patients advice to support their health.

The service had relevant information promoting healthy lifestyles and support in clinics. There were multiple leaflets available in clinics written by respected organisations to advise women on all stages of pregnancy and miscarriage. The service kept leaflets about miscarriage in the scan room, this way these could be handed to patients who needed them and would not increase anxiety in women who may already be concerned.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. Patient consent forms were scanned and stored electronically. Written consent was required for any scan of patients aged 16 or 17, for any internal ultrasounds or for blood tests to be carried out. For all other scans verbal consent was gained by the sonographer before proceeding.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Sonographers underwent consent training when they started with the service.

Staff made sure patients consented to a scan based on all the information available.

Staff understood Gillick Competence and Fraser Guidelines and supported young people who wished to make decisions about their procedures. There was a specific consent form for 16-17 year olds to sign prior to undergoing a scan, staff understood their responsibilities in assessing whether a young adult was able to consent for a scan. Patients under the age of 16 were not seen by the service.

Clinical staff received and kept up to date with training in the Mental Capacity Act.

Are diagnostic imaging services caring?

Good

We previously did not have the authority to rate this service. However, on this inspection we rated it as **good.**

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients were given time and privacy to undress prior to a examination and there was a screen in each scan room to allow for this. Staff explained the process to patients in a clear and kind manner.

Patients said staff treated them well and with kindness. Patients told us they felt the sonographers "were professional" and "fantastic" and said they would give "10/10" for the service. They told us they didn't feel appointments were rushed at all.

Staff followed policy to keep patient care and treatment confidential. We observed a clinical assistant ask a patient to fill out a questionnaire with personal

information. This was then transferred into the electronic system and the paper copy was immediately shredded. This meant the patient did not have to verbally confirm personal details in a waiting room.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The service had a clear privacy dignity and respect policy that detailed how staff should respect patient choices and only request they remove minimal clothing for scans, offer a chaperone for all intimate scans and to consider how to communicate with patients if English was not their first language. All patients had the opportunity to request a chaperone for any appointment, on the consent form for internal ultrasounds there was a specific question about whether the patient would like a chaperone present.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff being attuned and supportive to patient and relative needs. When patients or relatives seemed to be getting distressed they took their time and explained what could be seen on the screen and what it meant.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff told us patients were generally calm until they had received bad news in the scan room. If sonographers had to deliver bad news to patients, they kept them in the private scan room until they were ready to leave. We were told by sonographers there was no pressure to keep to appointment times when bad news had to be delivered, and that patient needs were to be prioritised. Sonographers offered to refer patients to their local NHS trust for further advice and treatment. Staff followed up with patients a few days after breaking bad news to them to ask how they were.

Sonographers undertook training on breaking bad news. Full time sonographers were offered advanced communication training to enable them to break bad news to patients in a clear and caring way, sessional staff generally had this communication training as part of the main, NHS role. Communication was audited by the service to ensure patients were given in formation in a way they would understand.

The service had leaflets from a well known charity to hand to patients to provide advice if they were going through a miscarriage. These leaflets were kept in the scan room and were not displayed in the waiting room with other leaflets. We were told this was so patients who might be anxious while waiting would not be faced with leaflets about their fear, potentially increasing this anxiety.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff had access to leaflets about charities to support patients having a miscarriage and told us they would always offer these to patients.

Understanding and involvement of patients and those close to them

Staff supported and involved patients and those close to them to understand their scan results and to make decisions about which scans to have.

Staff made sure patients and those close to them understood their scan. In the scan room all sonographers we observed were clear in their communication with patients and relatives. They explained what they were about to do, what this should show and then what could be seen on the screen. They then explained why what could be seen was normal or outside of normal and what this would mean going forwards. Sonographers took time to answer questions throughout the scan and gave patients and relatives time at the end of the scan to ask questions. Sonographers also explained when there were times that they would be quiet to take measurements or to concentrate, this was to prevent patients and relatives from worrying about what was being seen.

Clinical assistants were clear with patients and those close to them about the cost of their scan, and when extra costs might be incurred. For example, patients having a 'babydate' scan were warned if the pregnancy

was very early on it may not be possible to visualise with an external scan, if this was the case an internal scan would be needed and this carried an extra charge. Patients were routinely told this before having the scan, so the extra cost was not a surprise. The service's website also explained each scan package in detail, explaining what was included, how long the scans should take and the price. This meant patients were able to choose a package that suited them

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff minimised use of technical terminology and explained processes and results in a way that patients could understand. Patients told us they felt the sonographers gave them a "good explanation" as to what was happening throughout the scan.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service. The service used an external review website to collate their feedback, this was done nationally and could not be broken down for each clinic. In clinic waiting rooms there were comment boxes where patients could write positive or negative comments about their experience of the service.

Information about the imaging options available was available on the organisation's website. This included and explanation of what each scan involved, the average scan length and the price of each scan type.

Are diagnostic imaging services responsive?

Good

We previously did not have the authority to rate this service. However, on this inspection we rated it as **good.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and organised services so they met the changing needs of the local population. Ultrasound Direct London was not commissioned to provide any NHS services; therefore service provision was driven by patient demand. There were a number of clinics open across London meaning there was normally one local to where patients lived. There were appointments opened on evenings and weekends to fit with the needs of the patients they served.

Facilities and premises were appropriate for the services being delivered. However, some clinics did not have step free access. We were told that clinical assistants would warn people of this over the phone, if they took a telephone booking however appointments could also be booked online and there was no mention on the website of there not being step free access. Managers told us patients would be informed about the lack of step free access when clinic assistants confirmed appointments over the telephone. Following inspection we raised this with the managers and as a result they have made changes to the website to reflect which clinics could not offer step free access.

Staff ensured that patients who did not attend appointments were contacted. If a patient was approximately five minutes late the clinical assistant running the appointment list would call the patient and check they were well and could find the clinic. If a patient missed their appointment they would lose the deposit of £30, this was clearly written in the terms and conditions. As long as a patient gave more than 48 hours notice they were able to cancel an appointment without any charge.

Meeting people's individual needs

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.

Staff understood how to meet the needs of a patient with additional communication needs or patients with a disability. Staff were clear about how they could adjust their approach for patients with physical or learning disabilities. Sonographers explained they would scan patients in their wheel chairs if needed, to minimise the risk of moving a patient to the scanning couch. If a patient had a learning disability the sonographers explained, if this was known before the appointment, they would give a longer time. This would enable them to spend extra

time explaining to the patient what was happening and to make sure they had understood the results. Due to the nature of the services offered the service rarely cared for patients living with dementia.

Managers made sure staff, and patients, relatives and carers could get help from interpreters or signers when needed. If a patient could not understand English sonographers had access to a telephone interpretation service, meaning they could get conversations translated as the scan was happening.

The clinics were all secured and required patients to be given access. They were not all accessible from the street for patients with mobility issues. We were told that clinic assistants would make patients aware of this at booking. However, patients were able to book appointments online and there was no mention of accessibility on their website. This could mean patients were able to book appointments online and not know they could not access the clinic. Following inspection we raised this with the managers and as a result they have made changes to the website to reflect which clinics could not offer step free access.

Access and flow

People could access the service when they needed it and received the right care promptly.

Managers monitored waiting times and made sure patients could access services when needed. The service used an online booking system and appointments were bookable three months in advance. The booking system worked in conjunction with sonographer availability and competency, ensuring a sonographer was not booked to carry out a scan when they were away on training or annual leave. Patients were also able to book appointments over the telephone.

Appointments were available from the morning through to the evening and also at weekends to ensure patients could find a time that suited them, outside of generic working hours. We were told patients could almost always be offered an appointment within a week of trying to book one. The longer waits were for more specialist scans, that fewer sonographers were qualified to carry out.

Staff worked to make sure patients did not stay longer than they needed to. Staff worked hard to keep to appointment times, there were often little gaps throughout the days bookings to help them stay on time if appointments had overrun. Clinic assistants added notes to appointments when patients were taken in late, so that this could be monitored. When patients were taken in late clinic assistants would explain that the sonographer was delayed and would work to estimate the length of the delay. We were told this was not always precise, as if a patient had been given bad news this could take some time, but that assistants would be as open as possible, while maintaining patient confidentiality.

Managers worked to keep the number of cancelled appointments to a minimum. In 2019, the year leading up to inspection, the service had cancelled only 22 appointments for non-clinical reasons. These were predominantly cancelled because of system failure or sonographer skill set availability. Patients were all offered appointments as soon as possible following the cancellation. We were told if a sonographer was off work unwell the clinic session would be offered to all other sessional sonographers before being cancelled to ensure all had been done to try and keep the clinic running.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible. If a patient's appointment did have to be cancelled at the last minute, due to a machine breakdown or a sonographer being unwell the service would offer an appointment at an alternative clinic or as soon as possible at the same clinic, if that was the patient's preference.

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.

Patients, relatives and carers knew how to complain or raise concerns. In 2019, the year leading up to inspection, there were 46 complaints about the service, 36 of these were managed under the formal complaint system and 15 of these were upheld.

Managers investigated complaints and identified themes. The service aimed to acknowledge a complaint within two days of receiving it and to have a formal response within seven days. The registered manager was able to

tell us previous themes they had identified as part of complaint investigation, such as patients not receiving the electronic links to their images, and how this was resolved. Another theme that had been identified was that patients felt they had not fully understood what they were told at their appointment. This was being looked at by the new regional manager and a new research project was being proposed to ensure staff understood patient expectations and needs when it came to explaining the results in a clear, consistent way.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. There was a clear complaints procedure for staff, which explained to staff how to acknowledge complaints and how to resolve them locally, if possible. Staff told us there were aware of the complaints policy and would be comfortable resolving complaints if they needed to.

Following inspection we requested to see the most recent responses to complaints and we saw patients were given a full explanation of what had happened, what investigation had happened and what action the clinic was planning to take in the future. The responses were detailed, factual and sympathetic.

The service clearly displayed information about how to raise a concern in patient areas. There were clear posters about how to complain to the service in the waiting rooms. In addition to this, any online reviews of less than three stars were followed up by the service to see what it could have done better to improve their service.

Are diagnostic imaging services well-led?

Good

We previously did not have the authority to rate this service. However, on this inspection we rated it as **good.**

Leadership

Leaders had the, 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.

The business manager had a background in pharmaceuticals and managed the whole business. They had employed a regional manager who was a sonographer by background to support with the clinical management. Their skill sets complemented each other and both managers worked together to ensure both clinical and non-clinical concerns were addressed.

The regional manager told us they had been very well supported by the local business manager when they were first employed and that they were still happy to touch base with them when required to ask questions.

All staff we spoke with told us they found the managers to be approachable and that they would not hesitate to ask questions or raise potential improvements or concerns with them. The regional manager worked clinically sometimes and so was in touch with staff regularly and had a good understanding of what may be causing frustration to staff.

Vision and strategy

The service had clear aims for what it wanted to achieve.

The service had a clear statement of purpose and this set out the aims of the service. The service was in the process of developing values derived from the statement of purpose for staff to adhere to in day to day work. The values were aimed at making the statement of purpose more accessible for staff.

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.

All staff we spoke with told us they were happy to work for the service and that they felt the service offered high quality care to patients who wanted it. They told us they felt under no pressure to upsell products to patients as this could make them feel uncomfortable, but that if patients enquired about their extra products they were happy to explain them.

Staff told us the managers were very flexible and took their medical conditions and family lives into account

when allocating shifts. They told us this was one of the reasons they were so happy to work for the company as they saw their employees as people and cared for them also.

All staff we spoke with told us they were happy to speak to managers about concerns or ideas for changes. They said they were not worried that by raising a concern they would be in trouble and that mangers were always receptive to new ideas.

We observed positive working relationships between clinic assistants and sonographers throughout our inspection. Both staff groups appreciated each other's roles and listened and spoke respectfully to each other. Sonographers told us how much the appreciated the support of the clinic assistants and how they were always happy with how they ran the clinics and spoke to patients.

The service had a designated member of staff as a mental health support contact for staff to contact if they were struggling or upset by a situation. It was recognised by managers that staff faced some upsetting situations and they had put measures in place to try and offer support to them.

Governance

Leaders operated effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had an overarching escalation policy which clearly defined who was responsible for what and when to escalate issues and concerns to the next layer of management. This policy included customer complains and concerns, whistleblowing, performance management framework and critical incidences and operation failures.

There was an overarching Ultrasound Direct company clinical governance policy which laid out which members of the ultrasound direct senior leadership were responsible for what at a national level. This overarching policy also laid out the base needs for an audit programme, staff education and risk management.

Locally there was an effective governance structure that staff understood. Staff all had line managers, and could speak with them about concerns or ideas, additionally they were able to raise them up the regional manager. The regional manager could then raise these ideas and concerns to the franchise manager or directly to head office, if required. We were told head office was receptive to ideas to improve performance or quality and were in discussions with the regional manager about a new research project.

There were staff meetings scheduled every two months. There was a standing agenda, which staff were able to add to and the minutes were shared with staff following the meeting. We were told by the regional manger the meetings were booked on different days in the week and at different times to try and enable as many of their sessional staff to attend and contribute as possible.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

We were told the service completed environmental risk assessments annually, however we were provided with the 2018 environmental risk assessment and not one for 2019. We did find that the risk assessment was clear and comprehensive. There were clear actions in place, will accountable people assigned and dates for completion.

We were also sent an in date risk assessment for sonographers, focussing on the risks they faced in their work and how they mitigated these to keep them safe. We found this to be thorough and to have mitigations in place to reduce the risk of injury or increased stress levels to sonographers.

While we were on inspection we saw the response and changes to practice the service had already implemented in light of COVID-19 which were in line with national guidelines. This demonstrated the service was actively monitoring and working to reduce the risk of transmission to both staff and patients. The service had increased the frequency of cleaning, had increased the supply of hand sanitiser and were encouraging patients

to use it as soon as they arrived in the clinic. The service was also handing out information and guidance from the Royal College of Gynaecologists (RCOG) to their pregnant patients about the disease and pregnancy.

The service monitored performance using both regular audits and patient feedback, they then used this data to improve services as required.

The service had plans to cope with and manage emergencies. We were told that there had recently been a bomb scare in a car park near a centre and the policy had been followed safely by staff involved.

Managing information

The service collected reliable data and analysed it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Where possible results were given on the day of the scan and images and reports were sent to patients electronically, to be kept. There was a strict policy in place for the secure sharing of images and reports with patients to ensure privacy was maintained. This policy also detailed the long-term storage of images and reports and how these were securely maintained. While on inspection we found that all information governance principles were being upheld. Staff locked computers if they were not working on them, as soon information provided in paper format had been uploaded to the electronic system we saw that it was shredded and all computer systems holding patient information were password protected.

The service sent us notifications as we would expect and explained when they would notify other external organisations of concerns or problems as well.

Engagement

Leaders and staff actively and openly engaged with patients to plan and manage services.

As explained previously in caring, the service actively sought out the views of patients and those close to them by requesting feedback both electronically, once home, and in writing, while on site. They responded to all reviews online that were less than three out of five stars to find out what could have been improved and then used this to shape services.

The service also sought staff views on how to improve services and these were formally documented in staff meeting minutes.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The regional manager was working with Ultrasound Direct head office to begin a research project into fine tuning the communication between sonographers and patients using recognised communication methods. The regional manager said head office had been receptive to her ideas.

Ultrasound Direct ran an ultrasound school from their head office in Market Harborough. This school ran regular courses including phlebotomy, breaking bad news and specific site imaging training that staff from Ultrasound Direct London were able to access.

Outstanding practice and areas for improvement

Outstanding practice

The provider considered their staff's mental wellbeing and had a member of staff trained to support mental health wellbeing for staff to contact should they want to.

Areas for improvement

Action the provider SHOULD take to improve

The provider should continue to provide sinks in all clinical areas and not continue to rely on nearby bathrooms.