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Ultrasound Best

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Inspected but not rated
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We rated the service requires improvement because:

- The provider did not always operate effective governance to ensure staff practice aligned to policies and policies were not always up to date.
- The provider did not always fully identify and consider the risks to service users and staff and did not always collect enough information to safeguard people effectively.
- Staff did not always complete mandatory training on time and the provider did not always check they completed.
- The provider did not always operate robust recruitment processes to ensure staff were 'fit and proper' for their role.

However:

- The provider implemented innovative initiatives to support patients at risk of domestic abuse.
- The clinic environment was fit for purpose and a welcoming environment for service users and their families.
- Staff worked well together to support service users and were passionate about delivering good care. Service user's feedback was consistently positive.
- The service had effective systems in place to refer service users to other services if they needed to.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Requires Improvement 	We rated this service requires improvement. See the overall summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Ultrasound Best

Ultrasound Best is operated by an individual, sometimes referred to as a 'sole trader'. Individuals register in their own name as a legal entity and are directly responsible for carrying on the regulated activity at a service. Where the service provider is an individual, they do not need to have a registered manager unless they are not a fit person to manage the regulated activity, or they do not intend to be in day-to-day charge of how the regulated activity is provided. The individual provider of Ultrasound Best is a trained sonographer and qualified radiographer employed in the NHS, they perform all the scans delivered by the service. The provider employs reception and administrative staff to support the delivery of the regulated activity.

The service registered with CQC in January 2022 and is registered to provide diagnostic and screening procedures. We have not previously inspected the service.

The service is predominantly a private baby scan service but also offers scans to Service users concerned about fertility or pelvic pain. The service's website allows Service users to book fertility, early pregnancy, reassurance, presentation, and 3D or 4D scans.

The CQC recognises two types of baby scanning service: diagnostic and souvenir scanning. Diagnostic scans are defined as using ultrasound to check the health of a baby and check the pregnancy is progressing as planned. A souvenir scan is defined as using ultrasound to record pictures or videos of the baby to keep as a memento. Souvenir scans are not for diagnosing problems with a pregnancy. During our inspection of Ultrasound Best we found the provider referred to the service, in their terms and conditions, as 'non-diagnostic' however the provider told us they gave Service users verbal feedback about their baby's health and development. The provider also gave Service users a written report and referred them to NHS services if they had any concerns about the pregnancy. Therefore, we inspected the service under our diagnostic imaging framework.

How we carried out this inspection

We inspected the service using our comprehensive methodology. We carried out an unannounced on 4 July 2023. The inspection was overseen by a CQC Operations Manager.

To get to the heart of Service users' 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.

During our inspection we spoke with the provider and the 2 reception staff who were employed at the time of our inspection. We spoke with 4 Service users by telephone. We reviewed staff files, a sample of Service user records and other documents related to the delivery of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Summary of this inspection

Outstanding practice

The provider had a domestic abuse initiative in place which supported Service users to discretely alert staff if they felt at risk from someone they were with. The initiative advised Service users how they could let staff know, non-verbally, that they felt at risk and that staff would act upon this without attracting the attention of people they were with. Both the reception staff we spoke with were aware of the initiative and told us how they would respond.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure all staff complete mandatory training in key areas (Regulation 12(2)(c)).
- The service must ensure that robust recruitment processes are in place to ensure staff are 'fit and proper' to fulfil their role (Regulation 17(2)(d)).
- The service must ensure they store and retain records in line with policy and General Data Protection Regulations (Regulation 17(1)(2)(c)).
- The service must ensure that appropriate and up to date policies, systems and processes are in place to govern the service, support staff to do their roles safely and manage the risks to patients (Regulation 17(2)(a)(b)).

Action the service SHOULD take to improve:

- The service should ensure they collect enough information to support staff to report abuse effectively (Regulation 13 (2)).
- The service should ensure they collect enough information to fully assess risks to service users (Regulation 12(2)(a)(b)).
- The service should ensure cleaning records are completed and up to date (Regulation 12(2)(h)).
- The service should consider reviewing the incident management policy and processes to ensure staff can identify, report, and learn from incidents which do not result in illness or injury.
- The service should consider reviewing the early scanning procedure to ensure staff, service users and visitors are not exposed to unnecessary risk.
- The provider should consider reviewing how they define the service to ensure they are clear to service users, regulators and other professional bodies about the scope of the service and any limitations.
- The service should consider subscribing to an independent complaints review body.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Requires Improvement	Inspected but not rated	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Inspected but not rated	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Diagnostic imaging

Safe	Requires Improvement
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Is the service safe?

Requires Improvement

We rated safe as requires improvement.

Mandatory training

The service provided mandatory training to staff. However, they did not always make sure staff completed it.

The service had a mandatory training schedule for each staff role. The schedule included the key courses outlined in the UK core skills for health framework such as first aid, fire safety, health and safety, infection control and equality, diversity, and inclusion. The provider also included additional courses such as lone working and basic life support. However, not all staff completed all the key, and additional, courses listed for their role. For example, one receptionist did not complete first aid or general data protection regulation (GDPR). The provider told us they reminded staff to do their training but did not always check they completed it. The receptionist completed the remainder of their training a few days after our inspection.

The provider, who was the sonographer, completed mandatory training as part of their employment in NHS services. We reviewed the provider's NHS training record. They completed most mandatory and additional required training for their NHS role on time, however their equality and diversity training expired in June 2023. The provider also completed some training through the online training platform they used for reception staff. They completed some of the training, including equality and diversity, after our inspection.

Safeguarding

Staff understood how to protect Service users from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it. However, staff did not always collect enough information to report abuse properly and did not always consider the risks to children visiting the service.

The provider completed adult and child safeguarding training up to level three. This included recognising and reporting abuse as well as recognising vulnerabilities. Reception staff completed adult and child safeguarding training up to level 2.

Diagnostic imaging

The service had a safeguarding adults and children policy in place which described the definitions of abuse, how to recognise abuse and how staff should report this to the local authority safeguarding team. However, staff did not routinely record Service users' addresses and therefore did not always know which local authority area the Service user lived in if they needed to make a referral.

The provider was able to verbally describe examples where they would need to make a safeguarding referral. We saw evidence of good practice where the provider made a safeguarding referral when they identified concerns about a member of the public who submitted an enquiry to the service by email. The service also had a domestic abuse initiative in place to allow Service users to discretely alert staff if they felt at risk.

The service had a chaperone policy in place and displayed posters to advise Service users of their right to request a chaperone if they wanted one. However, the service's scanning procedure stated that Service users attending for an early pregnancy scan with children, should leave their children in the reception area until the sonographer was able to confirm the pregnancy. This was to avoid staff having to deliver bad news in front of children. This meant, if a Service user attended alone with children, reception staff would need to supervise the children in the reception area and would not be available to act as a chaperone. As well as the potential for conflict with the chaperone policy, the provider had not fully considered the other risks this practice might pose to the staff or the children they would supervise. The provider told us this situation had not arisen in the time before our inspection, and that the children would only be in the reception area for the first minute of the scan.

The provider required all staff to have a Disclosure and Barring Service (DBS) check as part of their recruitment. However, they were unable to provide evidence of a DBS checks for all staff on the day of our inspection. After our inspection, the provider gave us evidence of their DBS from their NHS employer and performed a basic check for the receptionist as they were not able to access their most recent certificate.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect Service users, themselves, and others from infection. They kept equipment and the premises visibly clean. However, staff did not always complete cleaning records.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. We saw the chairs, ultrasound couch and surfaces in the scanning room were wipeable and staff used disinfectant wipes to clean them between Service users.

Staff followed infection control principles including the use of personal protective equipment (PPE) and control measures. The provider followed the UK Health Security Agency (UKHSA) national Service user safety guidance on the use of sterile single-use bottles of ultrasound gel.

The provider told us staff cleaned the clinic every day it was open. There was a cleaning book where staff should record when they cleaned, however we saw staff did not always complete it properly.

Staff stored cleaning materials in lockable cupboards in line with control of substances hazardous to health (COSHH) guidance.

Environment and equipment

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

Requires Improvement

Diagnostic imaging

The clinic was located on a main high street where Service users could access parking nearby. The clinic was all ground floor level and made up of a large reception area, scanning room, kitchen, 2 bathrooms and storage cupboards. The reception area was welcoming with areas for children to play, souvenir stands and a variety of information for Service users to read.

The scan room contained an adjustable ultrasound couch for Service users which was wipe clean and well maintained. The sonographer covered the couch in disposable paper towel for each Service user and disinfected the couch between Service users. There was a large projector screen so Service users, and those accompanying them, could see the scans easily.

The ultrasound scanning machine servicing was up to date and all electrical equipment had up to date portable appliance testing (PAT).

Staff disposed of clinical waste safely. There was a clinical waste bin next to the scanning area where the provider disposed of used tissue roll, probe covers and disinfectant wipes between Service users. Staff stored full clinical waste bags in a large clinical waste bin in a private yard at the back of the clinic. Staff kept the outside bin locked and the provider had a clinical waste collection contract in place.

On the day of our inspection the Service user bathroom was out of order. However, the provider had made arrangements for repair and Service users were able to use the staff bathroom.

Assessing and responding to Service user risk

Staff did not always complete and update risk assessments for each Service user. They had processes in place to refer Service users to other services and staff quickly acted upon Service users at risk of deterioration.

The sonographer knew about specific risk issues and how to deal with them as they arose during scans. However, the service did not always risk assess individual Service users in advance of their scans. They did not routinely collect and document Service users' health conditions and pregnancy history for all scans. This meant, the sonographer did not always know if Service users had conditions, such as diabetes, that may make their pregnancy higher risk and therefore require particular focus or discussion with Service users. The service's terms and conditions for early pregnancy scans stated Service users should sign to agree they would provide this information however, there was not an area within the booking system where Service users were asked to input this.

The service had processes in place to refer Service users to the right NHS service if they identified any issues with Service users' pregnancies. The sonographer provided written reports for Service users to take with them to the NHS service and had pre-prepared envelopes with the names and addresses of local early pregnancy units or emergency departments on them.

Staff were able to verbally describe the steps they would take if a Service user or visitor became unwell during their visit to the clinic, this included contacting emergency services.

Staffing

The service had enough staff to keep Service users safe from avoidable harm.

Requires Improvement

Diagnostic imaging

The sonographer registered with CQC as an individual provider of the service. They employed two receptionists who worked an average of 1-2 shifts per week in line with opening hours at the time of our inspection. The provider told us they previously had an assistant manager who supported them with running the service, however the assistant manager left shortly before our inspection.

The provider told us there would always be at least 1 receptionist on duty whenever the clinic was open. This meant they were able to concentrate on the scans whilst reception staff booked Service users in and supported them to choose their images after their scan. The provider felt this staffing arrangement worked well. However, they acknowledged it might be difficult for them to manage to provide a chaperone to a Service user with only one other staff member present at the clinic. There was a risk staff would either have to leave visitors alone in the waiting room or lock the clinic door whilst the receptionist acted as a chaperone.

Records

Staff kept records of care and diagnostic procedures. Records were accessible, clear and up-to-date. However, staff did not always store records securely and in line with policy.

The service operated an electronic booking system. Service users could book and enter their details online or staff would enter their details electronically if they booked on the phone or in person. The electronic booking platform required Service users to enter their name, date of birth, email address, phone number and estimated due date, and to read and sign the service's terms and conditions, before the system allowed them to book a scan. Staff had access to Service users' details and signed form once they completed their booking. Staff could access and add additional notes to the Service user's record if they needed to.

During scans, the sonographer took images and made annotations using the ultrasound scanning machine. At the end of each scan, they saved these on to a USB stick. They then accompanied Service users to reception where staff uploaded the images to Service users' folder on the service's cloud-based storage system and on to a back-up USB stick. Staff then deleted all images from the sonographer's USB stick so they could use it again for the next Service user. The provider showed us examples of Service users' scans stored in this way and told us they were confident the cloud-based storage system was secure. The sonographer always kept their USB stick with them whilst in the clinic. Staff stored the back-up USB sticks behind the reception desk in a drawer, however the drawer did not lock.

Only the sonographer had access to the ultrasound scanning machine which stored the images the sonographer took. They told us they regularly deleted images from the machine to preserve memory. When we spoke with the provider, they were not able to say exactly how long they would keep Service user records and images stored on the Service user record and cloud-based storage systems. The service's data protection policy stated they would retain images for 1 year. The provider acknowledged they needed to check their data protection policy and privacy statement reflected the service's practice and was in line with general data protection regulations (GDPR).

Medicines

The service did not store or administer any medicines. The sonographer asked service users if they had any allergies before applying ultrasound gel or latex probe covers.

Incidents

The service had processes in place to record incidents. However, it was not clear how staff identified, recorded, and learned from incidents that did not result in illness or injury.

The provider told us there had not been any incidents since the service opened.

Requires Improvement

Diagnostic imaging

The service had an 'emergency and significant events' policy in place. The policy gave the service's description of 'significant events', 'major emergencies' and 'minor emergencies' The policy also described the NHS definition of a never event. Never Events are serious, largely preventable, safety incidents that should not happen because there is widely available national guidance about implementing preventative measures.

The service had a 'significant event and never events' reporting form and an 'incident form'. However, the policy did not provide guidance for staff about what they might class as an incident to record on the 'incident form'. Most of the incidents described in the policy related to accidents or injuries that staff or visitors might experience. The provider and staff described incidents as being emergency or significant events relating to health and safety. Team meeting minutes from January 2023 stated staff talked about how to report an incident and what to do if someone became unwell. However, the service's policy stated that breaches of confidentiality and complaints would also be 'significant events' because they may damage the reputation of the service. It was not clear what types of events staff would need to record as an 'incident' rather than a significant event, emergency or never event.

The service's website stated they did not scan Service users under the age of 18 and that Service user would need photo ID to prove their age. However, the service did not have a system in place to verify the age of Service users who visited the service. Staff told us there had been one occasion where a Service user who used the service turned out to be 17 years old at the time of their scan. However, the provider did not record this and did not implement a system to verify Service users' age.

During our interview with the provider, they described a situation where a Service user requested staff kept the gender of their baby secret from them, but that a staff member had accidentally revealed the gender whilst helping the Service user choose their images. The provider told us they apologised to the Service user and changed staff practice to prevent the same situation happening again. However, the provider was unable to say whether they would class this situation as an incident or document what had happened.

Is the service effective?

Inspected but not rated

We do not rate effective for diagnostic imaging services.

Evidence-based care and treatment

The service provided care based on national guidance and evidence-based practice, however policies and procedures did not always reflect this and were not always up to date.

The provider had a suite of policies and procedures in place to govern the service and staff told us they read them. However, not all policies included reference to best practice guidance. For example, the service had a scanning procedure which explained the process for scans from when Service users arrived at the service until they left. This included how the sonographer conducted scans. However, the scanning procedure did not reference best practice guidance published by professional bodies such as the British Medical Ultrasound Society (BMUS) and the Society of Radiographers (SoR).

Requires Improvement

Diagnostic imaging

The provider told us they based the procedures, and how they practised, on how they performed their role within NHS pregnancy services as this was based on national guidance. They were able to verbally describe how the scanning procedure aligned to elements of the guidance such as the 'as low as reasonably practicable' (ALARP) principle. BMUS described the ALARP principle as a fundamental approach to safer ultrasound scanning where the sonographer ensures they use the lower output power and shortest time to get the required diagnostic information they need during a scan.

The provider set an annual review date for the service's policies but did not review all policies annually. Some of the policies we inspected, such as safeguarding and data protection, had a review date of March 2022 but there was no record the provider reviewed them. Some policies, such as the scanning procedure, did not include a review date. Therefore, the provider could not be sure the policies contained up to date guidance and information.

Service user outcomes

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

The provider had a process in place to audit the quality of their scans. A qualified sonographer peer reviewed a random sample of 3 scans each quarter. They reviewed the quality of the scan images and the sonographer's notes. If the sonographer produced a report to support their referral of a Service user to NHS services, the peer reviewer also assessed the quality of the report. The provider told us they had not identified any missed abnormalities or other concerns during the audit process. They did not receive any complaints about the quality of images from Service users. The provider also participated in quality assurance processes to check the quality of their work in their role as a sonographer in NHS services.

Competent staff

Staff were competent for their roles.

The provider was a qualified radiographer registered with the Health and Care Professionals Council (HCPC) and worked in NHS pregnancy services. They participated in supervision, appraisals and quality assurance process in their NHS role and were able to verbally describe relevant competencies in line with the ultrasound practice for private baby scan clinics published by the Society of Radiographers (SoR).

The provider supported the reception staff to develop good customer service skills and an understanding of key issues in healthcare such as safeguarding and infection control. Staff told us they did not have formal supervision with the provider, but they regularly had informal discussions about their performance and development. One receptionist told us how the provider signposted them to training and information relevant to their field of study and made suggestions about how they could prepare for interviews.

The provider had a set list of mandatory training for reception staff however they encouraged staff to use the online training platform to complete additional healthcare related courses to increase their knowledge.

Multidisciplinary working

Staff worked together as a team to improve the service for Service users.

Diagnostic imaging

The provider held bi-monthly team meetings with staff. A member of staff recorded brief notes of team meetings in a notebook however there was no set agenda. We reviewed the notes of team meetings in January and March 2023 which showed staff discussed training at both meetings, but the other topics discussed were different. We saw the provider used the team meetings to remind staff about their responsibilities and to provide updates such as the installation of a new complaints post-box in the reception area.

During the January meeting, the provider also shared an example of poor practice they heard happened at another clinic and encouraged staff to ensure similar practice did not happen at the service. The provider reminded staff to ensure they were always polite and professional towards customers, thanked them for their effort and shared that Service user feedback was positive.

Seven-day services

Services were available to support timely Service user care.

The service's website enabled Service users to book appointments or submit queries online at their convenience. When the clinic was open, a receptionist was available to answer queries about the service or support Service users to book appointments. However, in line with guidance, staff, the website and the terms and conditions advised Service users they should not use private scans as an alternative to NHS antenatal pathways and they should seek medical support from their GP or hospital.

Health promotion

Staff gave Service users practical support and advice to lead healthier lives.

The service had a wide range of health promotion material available for Service users. This included leaflets about pregnancy specific issues such as baby movements, newborn nutrition, and support services as well as generic information about smoking cessation and exercise. The service provided Service users with packs which contained free samples from various maternity suppliers such as well-known pregnancy vitamin companies.

Consent

Staff followed processes to gain informed consent from Service users. However, the information Service users received was not always clear.

The service had a separate terms and conditions form for the different types of scans, such as early pregnancy, gender or 3D/4D scans. The service's booking system ensured Service users had read and signed the terms and conditions before they could finalise their scan booking. Staff ensured Service users who booked their scans by telephone, or in person, signed the terms and conditions relevant to their scan when they arrived at the clinic. Each form contained information, terms and conditions relevant to all scans and specific conditions relevant to the scan type. For example, the early pregnancy scan terms and conditions included Service user consent to the use of transvaginal probe if required to confirm the pregnancy. The form advised Service users they would also need to give verbal consent to a transvaginal scan on the day.

However, we found, some of the information in the terms and conditions was not clear about the scope of the scans. For example, the early pregnancy terms and conditions stated that the scan was 'non diagnostic', that the purpose of the scan was not to look for abnormalities and that the sonographer was not authorised to offer diagnostic opinion or

medical advice. However, the terms and conditions also stated that the sonographer would make an 'assessment of the status and development of the fetus' and that they could tell Service users if there was a possible anomaly and refer them to NHS services. Therefore, there was a risk Service users received contradictory information and may not fully understand the scope and limitations of the scan or the information they would receive.

The provider told us, in all scans, they would check the development of the fetus and give Service users verbal information about the progress of their pregnancy. Service users we spoke with described receiving information about their baby's development. For example, one Service user we spoke with told us the sonographer talked to them about their baby's brain development and showed them the chambers of their baby's heart. The CQC defines diagnostic scans as using ultrasound to check the health of a baby and check the pregnancy is progressing as planned. Therefore, we suggested that the term 'non diagnostic' within the terms and conditions may be confusing to Service users.

Is the service caring?

Good

We rated caring as good.

Compassionate care

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

Staff took time to interact with Service users and those close to them in a respectful and considerate way. Service users we spoke with gave consistently positive feedback about their interactions with staff.

Staff protected the privacy and dignity of Service users. The provider had installed a curtained off area within the scan room for Service users to use if they wanted to adjust or remove clothing before their scan. Reception staff understood the need to protect Service user's privacy and gave examples of actions they took to protect confidentiality.

Staff showed awareness of the possible personal, cultural, social and religious needs of Service users and how they might need to adapt to meet their needs.

Emotional support

Staff provided emotional support to Service users, families and carers to minimise their distress.

Staff gave Service users and those close to them help, emotional support and advice when they needed it. Service users we spoke with said staff were reassuring before and after their scans and were responsive to any questions they had.

The sonographer undertook training on breaking bad news as part of their role in NHS services and had experience of having difficult conversations with Service users. Reception staff told us they felt the sonographer was extremely supportive to Service users who they needed to refer to NHS services after their scans. They said they supported Service users to telephone the early pregnancy unit or their midwife and would explain the situation on the Service user's behalf if they wanted them to.

We saw the provider emailed Service users they referred to NHS services to ask if they needed any support. However, they were careful not to ask the Service users the outcome of their NHS appointment as they did not want to cause them any additional distress.

Understanding and involvement of Service users and those close to them

Staff considered the needs of Service users, families and carers

The clinic was a welcoming environment for families. There was an area for children to play in the reception and a variety leaflets and information available for partners and relatives as well as Service users.

The service had feedback cards and a box in reception where Service users and families left comments or complaints about their experience, Service users' partners or relatives completed some of the feedback cards. We reviewed a sample of feedback cards which were all positive, describing staff and the service as 'brilliant', 'amazing' and 'enjoyable'.

The provider told us they were careful not to break bad news in front of children as they did not want to cause them any distress.

Is the service responsive?

Good

We rated responsive 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.

The provider planned service delivery around the availability of themselves and staff. At the time we inspected the service was open on Saturdays and 3 days during the week. However, the provider would increase opening hours if staff availability allowed. The service's booking system was live so Service users were able to view available appointments for the month ahead. Available appointments times ranged from early morning to late evenings to ensure appointments were accessible for Service users who worked either in the day or in the evening.

The provider implemented a £10 deposit on booking to try to minimise missed appointments. The service's website was clear about the deposit and how the service would refund the deposit if Service users gave notice of cancellation in good time. The provider did not routinely contact Service users who missed appointments as they did not want to cause Service users distress if they had experienced complications with their pregnancy.

Meeting people's individual needs

The service was inclusive and took account of Service user's individual needs and preferences. Staff made reasonable adjustments to help Service users access services where they could, however they did not have any formal provision in place.

The service entrance was flat and accessible to wheelchair users. The rest of the service was on one floor and all rooms were accessible. The ultrasound couch was adjustable to support service users with mobility issues to get on and off the couch safely. The couch was able to accommodate bariatric service users.

The service did not have a contract in place with a translation service. However, the provider and staff told us they used free online platforms to translate documents and explain things to Service users if they needed them to. Staff gave some examples of when the sonographer had used online translation to explain a Service user's scan to them.

Staff were aware of other communication difficulties Service users might experience, such as deafness. Staff explained they would try to ensure they removed masks and maintain eye contact to support service users who needed to lip read. However, they did not have specialist systems to support service users with hearing aids, such as a hearing loop.

Access and flow

People could access the service when they wanted to, and staff ensured appointments ran on time.

Service users could book appointments online, by phone or in person at a time that suited them. Service users we spoke with told us they found it easy to book an appointment and did not have to wait long. We saw evidence the provider was responsive to email and social media enquiries about the service.

The provider planned for appointments to be up to 15 minutes long. However, they ensured each booking slot was 20 minutes long to reduce the chances of Service users having to wait due to overrun appointments. One Service user we spoke with had visited the clinic for 3 scans during their pregnancy, they told us their appointment had started on time every time.

Staff told us they would only cancel appointments if the sonographer or a receptionist were not able to attend the clinic due to sickness or other extenuating circumstances.

The facilities and premises were appropriate for the services delivered and the service provided reading material, toys and drinking water for Service users and visitors who were waiting.

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.

Staff told us there had not been any complaints since the service opened. However, they were able to verbally describe how they would manage a complaint. Reception staff told us they would raise any negative feedback with the provider as soon as possible. They felt the provider would always try to resolve Service users' issues informally straight away but would support them to complain if they wanted to. Staff were confident the provider would share the outcome of any complaints with them and talk to them about any improvements they might need to make.

The service had a complaints policy in place. The policy advised Service users could complain in different formats and through different channels such as via social media, reviews, in person or by telephone. It described the process the service would follow to record, acknowledge, investigate and respond to complaints effectively. If a Service user's complaint was about abuse, the policy included information about the local authority safeguarding team and local groups who could support Service users to complain. The policy also including signposting information about where Service users could escalate their complaint if they were not satisfied with the service's response. The Independent Sector Complaints Adjudication Service (ISCAS). However, ISCAS only review complaints from Service users if the provider subscribes to ISACS, we were unable to find the service listed as a subscriber on the ISCAS website.

The service had an area in the waiting room where Service users and visitors could leave feedback anonymously. We reviewed a large sample of the feedback cards left by Service users; we did not find any cards with negative feedback.

Requires Improvement

Diagnostic imaging

Is the service well-led?

Requires Improvement

We rated well-led as requires improvement.

Leadership

Leaders had the skills and abilities to run the service and were visible and approachable in the service for Service users and staff. However, they did not always have the capacity to understand and manage the priorities and issues the service faced.

The provider had the knowledge and skills to perform scans and manage the clinic. However, the provider struggled to balance the need to provide appointments and support people with the need to ensure regulatory compliance effectively. Alongside their NHS role and scans at the clinic, they did not always have time to check staff completed required documentation such as cleaning schedules and training modules. They acknowledged they needed support to manage the administration of the service since the assistant manager resigned a few weeks before our inspection and had started to look for a replacement.

The provider supported staff wellbeing and gave them advice to support their development. However, this was not always specific to their role within the clinic and therefore did not always support the provider's efforts to improve their position as the responsible officer for the service.

Vision and Strategy

The provider had a vision for what they wanted to achieve in the future however they had no detailed plans and acknowledged the need to focus on sustainability in the short term.

The provider did not have a documented vision and strategy for the service, but they were able to describe what they wanted to achieve. For example, as a qualified radiographer, the provider wanted to expand the scope of the service to perform other types of ultrasound scans such as muscular skeletal. They said they had talked to other qualified radiographers about their plans for expansion and the possibility of taking on an additional radiographer. However, the provider recognised the need to improve the governance of the existing service before looking to expand.

Culture

The service had an open and inclusive culture where Service users, their families and staff could raise concerns without fear. Staff felt respected, supported, and valued.

The staff and provider described a positive culture at the service. Reception staff said they felt valued and supported and demonstrated passion about delivering good customer service to Service users. Staff told us the provider supported them with their interests in healthcare and cared about them on a personal level.

Service users we spoke with said the clinic was a positive environment and that staff worked well together to support them. All Service users we spoke with knew the service collected feedback and said they would have felt comfortable to raise concerns if they wanted to. Staff understood the need to be inclusive and were aware of the possible personal, social and cultural needs of Service users and their families.

Requires Improvement

Diagnostic imaging

Governance

The provider did not always operate effective governance systems.

The provider had some governance processes in place. However, they did not always audit, maintain, or structure these effectively. For example, the provider had set up processes for staff to record their duties, such as cleaning. However, the provider did not always check staff had recorded them or that they had completed all their cleaning duties. They held regular team meetings with staff however there was no formal agenda and did not always revisit key topics such as incidents. They reminded staff to read policies and complete training but they did not always check which policies staff had read or what training they completed.

The provider did not always update or adhere to the service's policies. We found they did not always review policies on time and could not always evidence they followed them. For example, the services recruitment policy stated the provider would request a minimum of 2 employment references or 1 peer reference when recruiting staff. However, the provider was unable to evidence they collected these for both reception staff. Equally, the provider was unable to evidence they checked and stored all of the other recruitment documentation ahead of staff starting to work at the service.

Management of risk, issues and performance

The provider did not always fully consider the risks to the service.

The service's scanning procedure stated Service users attending for an early pregnancy scan with children, should leave their children in the reception area until the sonographer was able to confirm the pregnancy. The provider had not fully considered the implications for the service, or the staff, if a child suffered an injury whilst a receptionist supervised them.

The provider had a liability insurance policy in place. However, the terms of the insurance stated the scope of the service was 'non-diagnostic' and the insured business limited to 'taking, capturing, recording of images and data points only.' The policy excluded any 'diagnosis, interpretation, identification' undertaken. The service met the CQC definition of a diagnostic scanning service through the practices described by the provider. They offered services in line with other diagnostic ultrasound services such as fertility and reassurance scans. The provider acknowledged the need to effectively define the scope of the service and ensure they practised within this.

The provider had appropriate environmental risk assessments and testing in place.

Information Management

The service collected data and analysed it. However, they did not always store and retain it in line with policies.

The service had processes in place to record and store Service users' details. Online systems were secure. However, staff did not always securely store the USB sticks they used to back-up images. On the day of our inspection, the provider was not sure about the service's privacy statement and could not be sure how long they stored information after Service users' scans. The service's website and policy stated they would keep them for 1 year after each scan. The provider acknowledged they needed to check their data protection policy and privacy statement reflected the service's practice and was in line with general data protection regulations (GDPR).

The provider collected feedback from Service users from a variety of sources such as feedback cards, online reviews, and social media. We saw evidence they reviewed the feedback with the intention of using it to improve practice.

Requires Improvement

Diagnostic imaging

Engagement

The provider engaged well with staff, service users and the wider public.

The service had a public website which provided information about the scans they offered, their suitability at various stages of pregnancy and frequently asked questions. They used social media to communicate with the public and responded to online reviews from Service users and their families.

Staff told us the provider communicated with the team well. Although, reception team members often worked different days, they would attend team meetings together and had an instant messaging group which included all team members. They told us the provider would regularly communicate with them by instant message and this suited their lifestyle.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

We saw evidence, during and after our inspection, the provider and staff had started to implement changes based on the high-level feedback we gave them immediately after the inspection. The provider was keen to understand any potential shortfalls in their ability to meet regulatory requirements and use the inspection feedback as a catalyst for further improvements. They were aware of the need to create capacity for themselves to make improvements and demonstrated commitment to recruiting an assistant to support them with this. Staff we spoke with were enthusiastic about delivering the best service they could and were keen to learn more about the regulation of healthcare services and what they could do to support the provider.