Hey Baby 4D Manchester North West Ltd

Hey Baby 4D Radcliffe

Inspection report

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Radcliffe
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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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

The service has not been rated before. We rated it as good because:

- The service had enough staff to care for women and keep them safe. Staff understood how to protect women from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated women 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 women, families and carers.
- The service planned care to meet the needs of local people, took account of women's 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 their results
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Staff had not received training in paediatric basic life support
- Mandatory training in autism and learning disability awareness was not yet in place although staff had been enrolled on the training courses.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Good 	This service has not been rated before. We rated it as good. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Hey Baby 4D Radcliffe

Hey Baby 4D Radcliffe is an ultrasound scanning service providing scans for expectant mothers age 18 and over between six and 38 weeks of pregnancy. The service offers early pregnancy scans which includes internal scanning, wellbeing scanning and gender scanning. There are also 4D scans and late reassurance scans provided.

The service has been registered to carry out diagnostic and screening regulated activities since October 2020. Since this time the service has had a registered manager in post. A regulated activity is an activity involving or connected with, the provision of health or social care specifically in this case any procedure involved in examination of the body by ultrasound, including antenatal ultrasounds scans.

The service has not previously been inspected.

How we carried out this inspection

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We inspected this service using our comprehensive inspection methodology. Two inspectors, with support from an offsite inspection manager, carried out the inspection on 6 July 2022.

During the inspection we reviewed a range of documents related to running the service including, several policies and procedures, a training matrix, independent website browser platform and servicing records of equipment. We spoke with three members of staff including the registered manager and four expectant mothers who had used the service. We also reviewed four sets of patient records and staff records.

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.

Outstanding practice

We found the following outstanding practice:

- Staff were aware of the need for deaf expectant mothers to lip read. A free text facility on the screen used to show images of the baby enabled staff to communicate effectively, for example to tell the mother where the baby's head or bones, limbs and positioning were whilst still following infection protection and control guidance. In addition to this, staff were able to put the mother's hand onto the screen that played the sound of the baby's heartbeat. This enabled the mother to feel the vibration of the heartbeat instead.

- The service was working with a local charity to offer support packs for expectant mothers suffering early pregnancy loss. These packs included items such as tissues, a tea light candle and a crochet teddy bear and meant that the mothers had something to hold and touch in times of sadness and grief.

Summary of this inspection

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 that paediatric basic life support is completed in line with national guidance.

Action the service SHOULD take to improve:

- The service should consider the implementation of hand hygiene monitoring in line with the UK Health Security Agency IPC guidance and recommendations.
- The service should continue to implement audits around consent and documentation.
- The service should consider the introduction of a more robust recording method of risk so that actions, mitigations and level of risk can be identified by the service.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic and screening services	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Diagnostic and screening services

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

Are Diagnostic and screening services safe?

Good

The service has not been rated before. We rated it as good.

Mandatory training

The service provided mandatory training in key skills except paediatric life support to all staff and made sure everyone completed it

Staff received and kept up to date with their mandatory training. The mandatory training was comprehensive and met the needs of women and staff. This included mandatory training set out by Skills for Health Core skills framework such as adult basic life support, fire safety, health and safety, equality diversity and inclusion and infection prevention and control.

Clinical staff completed training on recognising and responding to women with mental health needs and managers and staff told us they were enrolled on training modules in learning disabilities and autism to meet new statutory guidance.

Managers monitored mandatory training by reviewing a manually inputted dashboard and alerted staff when they needed to update their training.

Training was not completed in paediatric life support despite the service welcoming families including young children into the service along with expectant mothers. This was not in line with Health Education England guidance on core service skills which sets out that all qualified healthcare professionals working with paediatrics should undertake training in paediatric basic life support.

Safeguarding

Staff understood how to protect women 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 level three adult and children safeguarding training on how to recognise and report abuse. All four members of staff had completed safeguarding training.

Staff could give examples of how to protect women from harassment and discrimination and knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Examples of professional curiosity were given.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

A safeguarding policy detailing relevant contacts, how to make a referral and defining adult and child at risk was available to all staff in written format at the main reception desk. A female genital mutilation policy was also available and kept adjacent to the safeguarding policy in one folder. Details of a multi-agency safeguarding hub (MASH) for the local area was also kept within the folder. The policies had been reviewed in June 2022 and contained up to date information and guidance.

Laminated posters were visible to staff and the designated safeguarding lead for the service was able to give advice and support having completed level four adult and children safeguarding training and having a wide variety of experience in safeguarding matters.

Domestic violence posters were also displayed in the toilet where expectant mothers were likely to be on their own and have the chance to see them.

Staff followed safe procedures for children visiting the service which included not leaving them unaccompanied at any time.

A chaperone policy was in place and a poster telling women of the availability of a chaperone was displayed at the reception desk.

The service completed pre employment checks including disclosure and barring checks (DBS), references and employment history. Two personnel files were reviewed and found to contain all the expected pre-employment checks.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were visually clean and had suitable furnishings which were clean and well-maintained. The furnishings were comfortable which was important for expectant mothers whilst waiting to be scanned.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment. There was regular lateral flow testing of staff so that expectant mothers were protected from contracting COVID-19 whilst at the service.

Staff cleaned equipment after contact with an expectant mother and labelled equipment to show when it was last cleaned. General cleaning of the scanning equipment was undertaken daily as well as additional cleaning after each use. Cleaning of a trans vaginal probe was in line with the Society of Radiographers transducer decontamination guidance.

Good

Diagnostic and screening services

The service did not have a hand hygiene audit in place at the time of the inspection. This meant the service could not be assured that staff were following the five moments of hand hygiene in line with NHS handwashing guidance for healthcare workers. A sink was installed in the scanning room meaning that staff could wash their hands immediately before and after each scan.

The service had commissioned a legionella test by an external company in May 2022 to ensure that water systems within the service were safe and did not contain any legionella bacteria which is harmful to people especially expectant mothers and their babies.

Environment and equipment

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

Staff carried out daily safety checks of specialist equipment. Such as the ultrasound machine, oxygen and first aid kits. Whenever ultrasound equipment was switched on checks were undertaken to ensure that correct settings were in place and in working order so as not to cause injury to the expectant mother or baby. Records demonstrated that checks were completed daily between 1st and 29th June 2022.

The service had suitable facilities to meet the needs of women's families, including water machines, toilets and baby change facilities.

The service had enough suitable equipment to help them to safely care for women. Including a first aid kit which was accessible to both staff and customers on the main corridor. A designated first aider was always on duty and staff had completed a basic first aid course meaning they had the knowledge to use it. All staff undertaking ultrasound scanning had completed training to enable them to safely use it.

Staff disposed of clinical waste safely each month and sharps bins were disposed of on an adhoc basis to suit the service's needs.

Ultrasound equipment was updated in 2022 with an expected five year life span. An annual service agreement was in place.

Portable appliance testing was completed annually and was due for renewal in May 2023.

The service had identified a lack of suitable private space for people receiving bad news. Current arrangements meant that the next customer would wait in the waiting room whilst the scanning room was used for difficult conversations. The service had listed this as a risk on the risk register and were in the process of seeking alternative arrangements.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and removed or minimised risks. Staff knew what to do and acted quickly when there was an emergency.

Staff responded promptly to any sudden deterioration in an expectant mother’s health and could offer basic first aid and call 999 for help. A deteriorating patient policy was in place. A medical emergency flow chart was laminated at the main reception desk so that staff could follow a step wise approach if they were unsure of how to respond to a medical emergency.

Good

Diagnostic and screening services

Staff completed risk assessments for each mother on arrival including allergies, identity checks, number of weeks pregnant, what scan they had come for and what they expected to get from the scan. This meant that the correct person received the correct scan.

The service had access to a mental health specialist midwife at the local NHS trust which they could liaise with if they had concerns about an expectant mother's mental health. An example of a recent referral to this service was demonstrated.

Frequency of scans were monitored and although no specific criteria for scanning frequency was set staff were able to decline to scan and where necessary refer into mental health services.

Women experiencing late intrauterine symptoms as an emergency situation were referred to the local NHS organisation by telephone and either transported by NHS ambulance or by making their own way.

A referral policy was in place and easily accessible to all staff detailing how to deal with unexpected findings or information of concern. This included providing an explanation of what has been seen and what the concern was to the expectant mother, stopping the scan and referring the mother to NHS diagnostic services for further investigation.

A referral form and letter were provided along with any appropriate images. A telephone call would be made to either the early pregnancy unit, midwife, hospital or general practitioner dependant on the scenario and the most appropriate method of transportation was arranged. This meant the service could be assured that people received care quickly, and unexpected or significant findings could be escalated appropriately.

A designated member of staff was assigned to a fire marshal role daily. A poster displaying the name of the member of staff was displayed by the main reception desk.

Another poster was displayed telling expectant mothers they could stop the scan at any time. This was also displayed at the main reception area meaning that expectant mothers could easily see it

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service has two sonographers, one was also a professionally registered midwife, and two administration assistants. Professional register checks were undertaken by the registered manager annually to ensure staff were appropriately registered.

Appointments were booked around staffing availability which was planned to be increased by two additional sonographers. Recruitment had not yet begun for these posts at the time of the inspection.

Agency staff were not used within the service, bank staff were given a local induction and had access to all reporting systems including incident reporting. All mandatory and safeguarding training of bank staff was monitored as part of the training matrix held by the registered manager.

Good

Diagnostic and screening services

Records

Staff kept detailed records of women's care and diagnostic procedures. 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. An ultrasound report was compiled at the end of the scan by the sonographer. A copy of this was given to the expectant mother and a copy retained by the service. The report included important details such as measurements, due date, presentation of baby, where the placenta sat and that the stomach, bladder and kidneys had been seen. This information could then be shared by the mother with the NHS midwife or their general practitioner.

Records were kept securely until scanned onto an electronic system. Paper copies were then destroyed, and electronic records kept for eight year in line with NHS England & improvement information governance guidance for healthcare workers.

Medicines

The service did not use medicines.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff knew to apologise and give women honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them, examples of needle stick injuries, collapsed mothers, trips and wrong type scans were given by staff as types of incidents they would report. This demonstrated that staff understood their responsibilities to raise concerns, record safety incidents and near misses.

The service had not had any serious incident within the last twelve months.

Although duty of candour had not been required staff understood what it was and how to apply it appropriately including giving women and families a full explanation when things went wrong.

Safety alerts were monitored by the registered manager and distributed to staff both face to face and in a communication folder.

Are Diagnostic and screening services effective?

Good

The service has not been rated before. We rated it as good.

Evidence-based care and treatment

The service provided care and procedures based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Good

Diagnostic and screening services

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The registered manager of the service subscribed to the Royal College of Gynaecologists, National Institute of Health and Care Excellence, Society of Radiographers, British Medical Ultrasound Society and Medicines and Healthcare Products Regulatory Authority. This meant any changes to national guidance could be identified and disseminated. In addition, a periodic search of UK based peer reviewed articles was undertaken so that any changes to evidenced based practice could also be identified.

The service worked closely with a local university by supporting students to undertake placements at the service. This helped the service to identify and share any changes and updates to best practice.

Policies including a recruitment and employment policy, referral policy, lone worker policy and safeguarding policy were in place. These were in date and referred to up-to-date guidance and legislation.

Patient outcomes

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

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Five clinical peer reviews were undertaken every month. There were 18 peer reviews carried out between March and June 2022 and demonstrated a 99% compliance rate.

Any areas of audit falling below the expected standard were subject to an action plan and increased monitoring.

Managers shared and made sure staff understood information from the audits and were involved in carrying out audits.

The registered manager worked clinically with members of staff and was able to share feedback with staff members face to face.

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 women. Additional training was provided to all members of staff in the assessment of risk and recording information.

One member of staff had been supported through an accredited training programme to enable them to carry out ultrasound scanning. This training programme had included working alongside the sonographer as well as the university link and building up skills from first trimester scanning to third trimester over the course of a year.

Managers gave all new staff a full induction tailored to their role before they started work which included a four-week supernumerary period of induction which could be increased if required. This meant that new staff had time to familiarise themselves with processes and practice at the service, forge links with peers and get to reliably understand the systems prior to working autonomously.

Managers supported staff to develop through yearly, constructive appraisals of their work. The next annual appraisal was due in October 2022.

Good

Diagnostic and screening services

Learning and development needs of staff were identified though clinical audit which was undertaken monthly as well as information conversations and an annual appraisal.

Managers made sure staff attended team meetings or had access to full notes when they could not attend by adding the meeting minutes into a communication folder that was accessible to all members of staff.

Multidisciplinary working

Staff worked together as a team to benefit women. They supported each other to provide good care.

The service could contact mental health midwives and liaise with the early pregnancy unit however no designated multidisciplinary meetings were held to discuss women and improve their care. Managers told us that attempts were made to collaborate with other services, but this had been unsuccessful. The service had set this as part of its strategy to engage more closely.

Seven-day services

Services were available to support timely patient care.

The service operated four hours an evening between Monday to Wednesday and a Friday, then between 9am and 5pm on a Saturday. The hours were set based on times of demand and could be flexed as required. For example, at the time of the inspection the service was operating an additional session between 9am and 12pm on three Sundays of the month.

Health promotion

Staff gave women practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in customer areas. Information leaflets about breast feeding and bottle feeding had been ordered to give to expectant mothers with the ultrasound report to support informed decision making. Discussions about smoking cessation would be undertaken on an individual basis dependant on need.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported women to make informed decisions about their care. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether an expectant mother had the capacity to make decisions about their care.

Staff gained consent from women for their care and treatment in line with legislation and guidance.

Staff made sure women consented to treatment based on all the information available.

Staff clearly recorded consent in the women's records. Five records were reviewed and demonstrated that consent was recorded appropriately. At the time of the inspection no consent audit was in place however managers told it was soon to be rolled out.

Good

Diagnostic and screening services

During the inspection we observed staff informing women of the limitations and risks associated with the scan prior to the scan being undertaken.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. There was 100% compliance for the four members of staff who had undertaken training in mental capacity awareness.

Staff could describe and knew how to access the Mental Capacity Act policy.

Are Diagnostic and screening services caring?

Good

The service has not been rated before. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way.

Women said staff treated them well and with kindness. This was also observed during the inspection.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each person and showed understanding and a non-judgmental attitude when talking about how they would care for women with mental health needs.

Emotional support

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

Staff gave women and those close to them help, emotional support and advice when they needed it. This included breaking bad news and undertaking difficult conversations.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. This included the use of specific words for example baby rather than foetus regardless of period of pregnancy as this was more likely to be understood and received by the expectant mother.

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

Good

Diagnostic and screening services

Understanding and involvement of women and those close to them

Staff supported women, families and carers to understand their condition and make decisions about their care and treatment.

Inspectors saw that staff made sure women and those close to them understood their care and procedures. Staff consistently explained the scanning process to the expectant mothers and their families.

Staff talked with women, families and carers in a way they could understand, using communication aids where necessary. For example, making sure that expectant mothers could see the wide screen which had images of the baby transmitted onto it and taking the time to explain what it was the mother was looking at.

Women and their families could give feedback on the service and their treatment and staff supported them to do this.

Women gave consistently positive feedback about the service. Four women were spoken to in person and electronic feedback was also reviewed, comments included calming demeanour, amazing experience, lovely, special experience.

Are Diagnostic and screening services responsive?

Good

The service has not been rated before. 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. This included flexible appointment times and good transport links including a bus route. Free car parking was available near to the service and signage outside of the location meant that people could easily access the service.

Managers monitored and took action to minimise missed appointments and ensured that expectant mothers who did not attend appointments were contacted.

Meeting people's individual needs

The service took a proactive approach to understanding the need and preferences of different groups of people including people with protected characteristic under the equality act. Staff made reasonable adjustments to help women access services.

Frosting on the front window of the service meant that expectant mothers could sit privately without passers-by looking in on them.

The service had information leaflets available to download in different languages spoken by the women and the website had a translate function so that people who spoke languages other than English could easily access the service. Telephone translation services could be used for translation during appointments.

Good

Diagnostic and screening services

Staff were aware of the need for deaf expectant mothers to lip read. Staff told us this was exceptionally hard during the COVID-19 pandemic when masks were worn. A free text facility on the screen showed images of the baby. This enabled staff to communicate effectively, for example to tell the mother where the baby's head or bones, limbs and positioning were whilst still following infection protection and control guidance. Staff were also able to put the mother's hand onto the screen which played the sound of the baby's heartbeat. This enabled the mother to feel the vibration of the heartbeat instead.

The font size on the website of the service could be adjusted so that large text could be selected.

Expectant mothers told us the electronic booking was easy to use

A water machine was available for people visiting the service and the service was wheelchair accessible including a disabled toilet.

The service had a chaperone policy in place.

The service was working with a local charity to offer support packs for expectant mothers suffering pregnancy loss. These packs included items such as tissues, a tea light candle and a crochet teddy bear and meant that the mothers had something to hold and touch in times of sadness and grief.

Access and flow

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

Managers monitored waiting times and made sure women could access services when needed.

Managers worked to keep the number of cancelled appointments to a minimum and made sure that when women did have their appointments cancelled at the last minute, they were rearranged as soon as possible.

Managers and staff worked to make sure women did not stay longer than they needed to and that booking time allocations were adhered to where possible. Each appointment time had been increased to ensure that the allocated time was enough.

Staff supported women when they were referred or transferred between services by follow up calls and repeat appointments where appropriate.

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. The service included women in the investigation of their complaint.

Women, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in customer areas.

Managers investigated complaints and looked for themes. The service had a system for monitoring complaints. Five complaints had been received since January 2022. All had been resolved without the need to escalate to the Independent Services Complaint Advisory Services and no specific themes were noted.

Good

Diagnostic and screening services

Staff understood the policy on complaints and knew how to handle them including escalating them appropriately to a senior member of staff.

Are Diagnostic and screening services well-led?

Good

The service has not been rated before. 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 women and staff.

Leaders had the skills, knowledge and experience to run the service well. They understood the challenges they faced and were clear about their roles and accountabilities.

Leaders were both visible and approachable to staff and worked closely with them to support the effective running of the service.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The service understood what it wanted to achieve and how it planned to achieve it. This included setting up closer working with local midwifery units such as some shared training and supporting students from accredited organisations with placements to support development of the students and growth of the service.

Staff we spoke with understood the strategy for the service and felt able to contribute at regular team meetings.

Culture

Staff felt respected, supported and valued. They were focused on the needs of women receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women, their families and staff could raise concerns without fear.

Staff felt supported and were proud to work for the organisation. The culture of the organisation was centred on the needs and experience of the people who used the service. For example, staff had identified and worked with managers to create additional support for women suffering early miscarriage. From this, one member of staff was undergoing training in basic counselling and a coffee morning support group was being created.

A secure instant messaging service was set up between staff and mangers meaning that staff had a direct route for accessing managers whenever they needed.

Good

Diagnostic and screening services

Equality and diversity were promoted within and beyond the organisation. Staff had completed training on LBGTQ+ awareness and staff understood and asked expected mothers their pronouns. Awareness of transgender mothers in the scanning process was an example given by staff of equality, diversity and inclusion.

Concerns could be raised by staff without fear of blame and information about how to raise concerns was available both electronically and in writing meaning expectant mothers and their families had a voice.

A lone worker policy was in place within the service and staff were prevented from lone working so that there was always a member of staff who could get help or raise the alarm if needed. This meant that staff felt safe in their workplace and did not worry about coming into work.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. 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 held regular governance meetings. These included team meetings every other month. Minutes of the 11th June and 9th April 2022 team meetings demonstrated that customer feedback, infection prevention and control, incidents and complaints were discussed.

Quarterly formal managers meetings were held although due to the nature of the service informal meetings were held almost daily. We reviewed the minutes of the April 2022 meeting and saw that customer feedback, staffing levels, booking systems and mandatory training updates were discussed.

Quarterly franchise owner meetings were also undertaken. Meeting minutes for April 2022 showed that audit, documentation, and information technology updates such as the translation function on the website were discussed. This meant there were effective structures and processes in place to support the delivery of good quality person centred care.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues but did not effectively record risk to demonstrate identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Staff were made aware of the services policies and procedures electronically and key information was kept in a communication folder at the main reception.

Performance was monitored through clinical audit and reviewed at regular governance meetings to identify where actions need to be taken.

Risk assessments were carried out by the service, managers could identify their main risks and anyone within the service was able to recognise and report risk meaning that arrangements were in place for the identification and management of risk.

Good

Diagnostic and screening services

Recording of risk was not always effective. The risk database consisted of a spreadsheet with 142 identified risks. Some risks had been resolved but not removed such as mops being used in all areas. Other risks did not demonstrate a reduction in the level of risk after actions had been undertaken. Risk scores had not been assigned meaning it was difficult for managers to easily review all 142 risks listed.

The service had a process in place for managing disruption to service which included expectant mothers having their scans at another local scanning service ran by the same provider.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service had arrangements for the confidentiality of patient identifiable data, records and data management systems in line with the General Data Protection Regulation.

Relevant information was accessible to all staff and information was used to measure performance and improvement. The registered manager had a training matrix to monitor mandatory training compliance, automated booking system and incident reporting system. This meant the service was using information technology systems effectively to monitor and improve quality of care.

Engagement

Leaders and staff actively and openly engaged with women and staff to plan and manage services. They were in the process of collaborating with partner organisations to help improve services for women.

The service engaged with the public through social media platforms which enabled the public to contact the service directly and instantly. Feedback was gathered by the service and used to shape and improve the service. For example, feedback had led to an additional weekend appointment being created.

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.

The service was striving for continuous learning and improvement and planned to increase staffing so that it could support expansion of its service. Managers anticipated this would provide a better service for expectant mothers as it would mean the service would operate for more hours and could offer more flexibility around appointment bookings.