Before the Stork

Quality Report

29 Sefton Street
Litherland
Liverpool
L21 7PD
Tel: 0151 280 0543
Website: www.beforethestork.co.uk

Date of inspection visit: 26 February 2019
Date of publication: 23/07/2019

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Not sufficient evidence to rate
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Before the Stork is an independent provider established in 2006 to provide parents with a memorable keepsake of their pregnancy through professional images and film of their unborn baby using ultrasound equipment.

The service report to have performed more than 15,000 scans since establishment.

The service is in Litherland, Liverpool, with good transport links and on-street parking. The service is located on the ground floor of a privately leased property. The service offers early pregnancy reassurance scans (from seven to 16 weeks pregnancy), sexing/gender scans (from 15 to 23 weeks pregnancy), 3D and 4D scans undertaken in HDLive (from 24 to 32 weeks pregnancy) and growth and presentation scans (from 24 to 34 weeks pregnancy).

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced visit to the service on 26 February 2019.

To get to the heart of clients' 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.

The main service provided by this service was diagnostic imaging for baby keepsake scan pictures.

Services we rate

We had not previously rated this service. We rated it as **Requires improvement** overall.

We found some issues with practice in relation to the service:

- The service needed to update its safeguarding training, to bring it in line with current guidance.
- The service needed to update its safeguarding policy, to bring it in line with current guidance.
- The service needed to be assured that sonographers had undertaken the appropriate level of safeguarding training at their local hospital and could evidence this.
- The service did not have robust systems in place to meet the fit and proper persons regulation.

However, we also found the following:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect clients from abuse and they knew how to recognise and report abuse.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- The manager monitored the effectiveness of care and used the findings to improve them.
- The service operated seven days a week.
- Staff cared for clients with compassion. Feedback from clients confirmed that staff treated them well and with kindness.
- Staff provided emotional support for clients to minimise their distress.
- People could access the service when they needed it.

Summary of findings

- The service treated concerns and complaints seriously, and had systems in place to investigate them and learn lessons from the results, and share these with all staff.
- The service engaged well with clients and staff to plan and manage services.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, to help the service improve. We also issued the provider with three requirement notices. Details are at the end of the report.

Ann Ford

Deputy Chief Inspector of Hospitals (North West)

Overall summary

The service has had a registered manager in post since opening in 2006. At the time of the inspection, this manager was in post.

The service offers early pregnancy reassurance scans (from seven to 16 weeks pregnancy), sexing/gender scans (from 15 to 23 weeks pregnancy), 3D and 4D scans undertaken in HDLive (from 24 to 32 weeks pregnancy) and growth and presentation scans (from 24 to 34 weeks pregnancy).

The inspection took place on the 26 February 2019.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Requires improvement 	**Before the Stork is an independent provider established in 2006 to provide parents with a memorable keepsake of their pregnancy through professional images and film of their unborn baby.** **We rated this service as requires improvement because the service could not assure itself that the staff had received the right level of safeguarding training and the safeguarding policy was not in line with current guidance.**

Summary of findings

Contents

Requires improvement

Before the Stork

Services we looked at
Diagnostic imaging

Summary of this inspection

Background to Before the Stork

Before the Stork is a baby keepsake scanning service opened in 2006. It is based in Litherland, Liverpool. The hospital primarily serves the communities of the local area, but it also accepts clients from outside this area.

The service has had a registered manager in post since opening in 2006. At the time of the inspection, this manager was in post.

The service offers early pregnancy reassurance scans (from seven to 16 weeks pregnancy), sexing/gender scans (from 15 to 23 weeks pregnancy), 3D and 4D scans undertaken in HDLive (from 24 to 32 weeks pregnancy) and growth and presentation scans (from 24 to 34 weeks pregnancy).

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 the Head of Hospital Inspection, Judith Connor.

How we carried out this inspection

During the inspection, we visited the service. We spoke with two staff including a sonographer and the registered manager. We spoke with four clients. During our inspection, we reviewed seven sets of client records.

Information about Before the Stork

The service has one location and is registered to provide the following regulated activities:

- Diagnostic and screening procedures.

  There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The most recent inspection took place on 20 June 2013, which found that the service was meeting all standards of quality and safety it was inspected against.

  Activity (2006-2019)

  - The service report to have performed more than 15,000 scans since establishment.

  Track record on safety

  - No never events.
  - No clinical incidents.
  - No serious injuries.
- Two complaints.

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?

Requires improvement 

We had not previously rated this service. We rated it as **Requires improvement** because:

- The service needed to update its safeguarding policy, to bring it in line with current guidance.
- The service needed to be assured that sonographers had undertaken the appropriate level of safeguarding training at their local hospital and could evidence this.

However:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect clients from abuse and they knew how to recognise and report abuse.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- Staff ensured detailed consent forms were completed for each client and a copy of this would be kept for up to three months after the date of the scan.
- The service had systems in place to manage incidents.

Are services effective?

Not sufficient evidence to rate 

We do not currently rate the effective domain for diagnostic imaging services, however, we found:

- The manager monitored the effectiveness of care and used the findings to improve them.
- The service made sure staff were competent for their roles.
- The service operated seven days a week.
- Staff understood the importance of health promotion.
- Staff understood the importance of obtaining informed consent, and when to assess whether a client had the capacity to make decisions about their care.

Are services caring?

Good 

We had not previously rated this service. We rated it as **Good** because:

- Staff cared for clients with compassion. Feedback from clients confirmed that staff treated them well and with kindness.

Summary of this inspection

- Staff provided emotional support for clients to minimise their distress.
- Staff involved clients and those close to them in decisions about their care.

Are services responsive?

Good

We had not previously rated this service. We rated it as **Good** because:

- The service planned and provided services in a way that met the needs of local people.
- The service took account of people's individual needs.
- People could access the service when they needed it.
- The service treated concerns and complaints seriously, and had systems in place to investigate them and learn lessons from the results, and share these with all staff.

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

- Improve facilities for those people who do not speak English as a first language.

Are services well-led?

Requires improvement

We had not previously rated this service. We rated it as **Requires improvement** because:

- The service did not have robust systems in place to meet the fit and proper persons regulation.
- The service needed to be able to assure itself that it could evidence that all staff members had been through a robust employment process and that they could provide evidence of qualifications and disclosure and barring service checks having been completed.

However:

- The service engaged well with clients and staff to plan and manage services.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement

Requires improvement

Diagnostic imaging

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

Are diagnostic imaging services safe?

Requires improvement

We had not previously rated this service. We rated it as **requires improvement.**

Mandatory training

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

The registered manager always worked alongside one of the sonographers. Each of the sonographers worked at a local acute hospital and so we were told received mandatory training under their own NHS trust. This included training in basic life support.

The sonographers operating the scanning equipment were all qualified staff members who were used to using this equipment on a daily basis. However the service also offered more specialist 4d specific training from an 'application specialist'. We were told that an 'application specialist' was a highly trained professional provided by the manufacturer of the scanning equipment for specialist in-house training and that this had been provided for all the staff. Staff told us there was support and training available at any time and they would always come to demonstrate to staff if there was anything new added, or any new members of staff starting.

We saw evidence the registered manager had completed training in accidents and incidents, diversity and inclusion, prevention of work related musculoskeletal injuries, fire safety and data protection. All other staff members were up to date with training, which included manual handling, managing incidents, health and safety and risk assessments. Staff were also trained in trans-vaginal decontamination, which we were told was done every two years and all staff were up to date with this.

Safeguarding

Staff understood how to recognise abuse and how to protect clients from abuse, however there was no evidence that staff had completed the required level of safeguarding training.

We were told that the sonographers undertook safeguarding training within their own trusts which would be safeguarding adults level one and two and the two midwife sonographers would also undertake level three safeguarding children training. The provider did not have a system for reviewing and recording completion of the training and could not provide us with evidence to confirm staff had completed training. This meant the provider could not be assured that staff were appropriately trained.

Administrative staff undertook safeguarding training on a yearly basis. The training covered different types of abuse and what to do on disclosure and it also contained contact numbers for relevant agencies.

We saw evidence of the service having a safeguarding policy. Staff told us the policy was reviewed on a two-yearly basis, however the document was dated 2013, with a recorded review date of 2015. On asking, this had not been updated as it was felt this was still current although it was not in line with current intercollegiate guidance. There was also information available on female genital mutilation. However, following inspection, the registered manager was keen to address this to update the policy to ensure it was current.

Requires improvement

Diagnostic imaging

Whilst on site, staff told us that there had only ever been one incident, where possible abuse had been suspected and that had been just prior to inspection. Staff described how they had managed the situation, ensuring that the lady was seen privately on her own and asked regarding possible signs of abuse. This had turned out to be a medical condition, but had been managed accordingly.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

During our inspection, we observed the sonographer using gloves to conduct the scan. Procedures carried out were usually non-invasive (external) and the ultrasound scans were performed transabdominally and involved minimal contact with clients. We observed the ultrasound probe was cleaned before and after client use. The service could offer transvaginal scans (only if required), but this was rare. There was a clinical waste bin in the scanning room which was used for the safe disposal of probe covers if an internal scan was needed and we were told that any clinical waste was collected from an independent company monthly.

We saw that there was a daily housekeeping schedule for both the scanning room and all other areas of the service. We saw that these had been completed daily and all areas of the service appeared to be clean and tidy. Although there was no dedicated domestic staff employed, all the cleaning was completed by the staff who worked at the service.

Soap, hot water, paper towels and hand gel were readily available and we saw the sonographer use gel regularly.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

The building was privately leased. On entering the service, there was a reception area and comfortable seating within the waiting area. There was also a chair and table for clients to view and choose scan pictures, as well as a cabinet with items available to buy. There was a kitchen area and bathroom facilities were also available. The treatment room contained a treatment couch and a large television monitor was mounted to the wall, on which the images were displayed. There was an ultrasound system which was maintained under a manufacturer's service contract with an ultrasound company. This was regularly serviced to ensure that it was safe to use and we saw evidence that this was current and in date.

The service had maintenance completed by approved contractors, which included fire extinguishers, which had a yearly service.

Assessing and responding to risk

Staff completed detailed consent forms for each client.

On arriving at the clinic for a scan, there were laminated information sheets offered to clients for them to read which had information regarding ultrasound and infrasound and whether any risks were attached to having scans. This information was from the Health Protection Agency (now known as Public Health England). On the service website, there was also a link to this information.

The service used a client consent form for the scans provided. These were used to inform clients about the services provided and to encourage discussion of requirements and potential concerns prior to any service being carried out. The forms advised women that scans were conducted according to British Medical Ultrasound Society (BMUS) recommendations for 'as low as reasonably achievable' (ALARA) principles for safety in ultrasound scanning, for length of scan and frequency.

We observed staff having good interaction with clients, clearly explaining what the forms were for and requesting that they were signed once read and understood. We reviewed the consent forms and saw that the terms and conditions were attached. The consent form also detailed that the service was not completing a scan to look for abnormalities and they were not to replace the routine scans needed.

The service did not offer diagnostic imaging services. Staff told us the scans were not intended to be diagnostic and did not replace routine hospital scans. This was reflected on the service's website and we also observed ladies being told this on attendance for scans. Staff ensured detailed consent forms were completed for each client and a copy of this would be kept for up to three months after the date of the scan.

Requires improvement

Diagnostic imaging

If an abnormality was detected during the scanning process, staff followed clear pathways that also detailed who to contact at which hospital dependent on the gestation of the lady. All the unit/ward contact details were also available on the pathways we saw. If urgent, the maternity provider was contacted before the client left, so that appropriate arrangements could be made for follow up. With client consent, if follow-up was required, the service could supply scan results to relevant healthcare professionals. Staff told us that the service had built good working relationships with local acute hospitals who were often very responsive to any issues they identified.

There had been no incidences of detecting intrauterine death (after 20 weeks gestation) since the service was established in 2005. However, staff told us that if this occurred, the findings would be explained to the client and they would be immediately referred to their maternity provider with a report for a formal rescan to confirm findings. In the event of a probable miscarriage (less than 20 weeks), the same process would occur.

The service also used a 'buddy system', which meant that aside from the sonographer on duty each day, there would always be another sonographer available from the service for advice, or support over the phone.

There was no resuscitation equipment on the site, but as the sonographers also worked at the local acute hospitals they were trained in basic life support. Staff told us that in an emergency, they would immediately phone '999' for urgent medical assistance. Staff told us that whilst open to the public, there would always be a sonographer working alongside another staff member.

Staffing

The service had enough staff with the right qualifications, skills and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The service was comprised of three directors, one of whom was a qualified medical radiographer/ sonographer. There were also three other qualified sonographers one of whom was a radiographer/ sonographer and there were also two midwife/ sonographers.

The service only used fully qualified staff who were trained in the safe use of ultrasound and ultrasound equipment to ensure that scans were of high quality and were safe.

The service did not use agency or bank staff and there had been no vacancies in the 12 months prior to inspection.

Records

Staff kept records of clients' care

Client records were in electronic format. All pictures, reports, referrals and forms completed were uploaded to the computer system and paper copies were then securely destroyed. These were all kept for a period of three months. Access to the computer system was password protected. This was a generic password that was changed six monthly.

With prior consent from the client, records could be shared with relevant healthcare professionals, such as GPs or NHS maternity services.

Incidents

The service had systems in place to manage incidents.

In the 12 months prior to inspection, there had been no 'never events' or serious incidents, although there was an incident form for them to use if required.

In the event of an incident occurring, staff said they would be open and honest with clients.

Are diagnostic imaging services effective?

Not sufficient evidence to rate

The effective domain was not rated.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

The service provided information and referenced relevant government websites, such as the British Medical Ultrasound Society guidelines from Public Health England (previously the Health Protection Agency) on their website and on the consent form.

Diagnostic imaging

The service used policies, which we were told were adapted if hospital policies changed, in order that they remained in line with national guidance. However, some of the policies we looked at did not have a clearly defined review date, but we were told these were reviewed each year.

Nutrition and hydration

Women attending for early scans were advised it is helpful to have a full bladder. A water cooler was available in the waiting area for those attending the scan to have a drink. As there were kitchen facilities, hot drinks could also be provided. All refreshments (hot and cold drinks) were provided free of charge at the service, but clients also had access to nearby cafes and shops, should they wish to use them. We also observed snacks such as sweets and chocolate available to purchase.

Patient outcomes

The manager monitored the effectiveness of care and used the findings to improve them.

Client experience was monitored through complaints and client feedback forms which were available in the reception area for clients to complete. We observed eight feedback forms and noted all were positive about the service they received.

Competent staff

The service made sure staff were competent for their roles.

There were four qualified sonographers who worked at the service, two of which were also qualified midwives. We saw evidence of sonography qualification as they all had their certificates framed on the wall in the reception area. Only the qualified sonographers undertook the scans and all the sonographers were employed by local NHS hospitals and were trained to medical diagnostic standards, with many years' experience in carrying out obstetric scans. We were told that all the sonographers all attended regular continuous professional development and mandatory training carried out by their NHS hospitals.

During our inspection we saw evidence of referral pathways to local NHS hospitals if any abnormalities were detected. As all the sonographers worked at local hospitals, they had good links with the NHS hospitals. The service also operated a 'buddy' system with one of the other sonographers from the service so that they could liaise with their peers for further clarification or advice if anything abnormal was seen on the scan.

As the service had a small team, we were told that regular communication ensured that any changes to local protocol was disseminated.

Multidisciplinary working

There were referral pathways to other agencies in place for staff to follow to benefit clients and all the staff worked together as a team to benefit the clients.

Information could be shared with other relevant professionals after consent had been obtained and the service worked very closely with acute providers, referring clients back to them as required.

Seven-day services

The service operated seven days a week.

There was a late-night opening until 9pm on two nights (Monday and Wednesday). This meant those who had commitments such as work or childcare could attend the appointment.

Health promotion

Staff understood the importance of health promotion.

We saw some information for ladies to read on counting kicks made by the baby.

Consent and Mental Capacity Act

Staff understood the importance of obtaining informed consent, and when to assess whether a client had the capacity to make decisions about their care.

The service had a consent form for women to read and sign and this included information by Public Health England and stated the scans were not diagnostic and they did not provide obstetric care or replace any scans with the NHS.

Consent was taken by whoever was working on the front desk, this would often be the registered manager. Each client was provided with a consent form on arrival and they were given time to read and sign it. The service terms and conditions and consent had to be signed prior to receiving the scan. Staff told us that they did not offer

an online booking system, so they could ensure that clients were the minimum age for attendance and that the appropriate consent was obtained before the scan could be completed.

We observed the sonographer asking the client to confirm what scan they had come for along with explaining and asking for confirmation to proceed to performing tasks such as applying gel onto the abdomen.

We reviewed seven consent forms and found them all to have been completed and signed accordingly.

Are diagnostic imaging services caring?

Good

We had not previously rated this service. We rated it as **good.**

Compassionate care

Staff cared for clients with compassion. Feedback from clients confirmed that staff treated them well and with kindness.

Clients were respected and their privacy and dignity was maintained.

We saw clients treated with warmth and compassion from arriving at the service, but particularly whilst having their scans. The sonographer explained each part of the baby on the scan and tried to show the baby's face as much as possible. Dependent on the gestation of the baby and for what reason the lady had attended, each lady and her partner or whoever had attended were asked if they wanted to know the gender of the baby. Many of the clients we saw on inspection were choosing to have gender reveal celebrations with their wider family and friends so had chosen not to find out at the time of the scan. The sonographer would ask them to look away when she was going to check for the gender of the baby, to ensure their surprise could be enjoyed at the time of their choosing.

We saw four scans during inspection and at each one, when the scan began, the sonographer put soft music on to enhance the experience of the scan for the mother and whoever had attended with her.

We reviewed 12 written feedback forms from women who had used the service. The questions related to ease of booking, the studio atmosphere and décor, helpful and knowledgeable receptionist and sonographer and the overall satisfaction of the service. Each question had an option of excellent, good, fair and poor and all the feedback forms we reviewed had a score of excellent against each of the questions. Some of the additional comments we saw included: - "amazing loving staff, couldn't fault anything", "amazing staff, very friendly and caring".

Emotional support

Staff provided emotional support for clients to minimise their distress.

We saw staff welcoming the clients through the front door and they responded to different emotions appropriately, in that if someone was excited for their scan, they would join in and share the excitement, but they were equally receptive to those attending who might have been nervous and would offer reassurance.

We saw the sonographer offering reassurance and comfort during the scan, and spent additional time answering any questions the woman and her partner, or family had about the baby.

The sonographers undertaking the scans would support women if they did not detect the heartbeat, or if any other abnormalities were found. The scans were done in a private scanning room with the door closed, so that further emotional support could be given to those needing it and for as long as necessary.

If any problems were detected, the staff from the service would liaise with local hospital providers to obtain further review, or follow up appointments and could often obtain an appointment time very quickly, to help in reducing further worry or anxiety for the woman.

Understanding and involvement of clients and those close to them

Staff involved clients and those close to them in decisions about their care.

The service encouraged women to bring along friends and family members (including children) to their ultrasound scan, if they so wished. During our inspection,

Diagnostic imaging

we saw women accompanied by various companions such as, their partner, parents and in-laws. We saw that everyone was made to feel welcome and included in the experience.

During our inspection we observed the sonographer explaining the images whilst they were on the screen to the mother and whoever was in attendance with them. This was done in a way that made it easy to understand, with full explanations of detail given. We saw different family members and, as well as partners attend with the women and we saw that relatives and friends were also welcomed to the service and involved in the excitement of the scans.

Following the scan, the women and their families had many images to choose from and during our inspection we observed they were not rushed in picking the ones they wanted.

Information regarding the different types of scans and packages available for people to purchase was clearly presented on the provider's website and deposits were refundable within 48 hours of cancellation.

We saw the service sought feedback from clients about the quality of service they had received.

Are diagnostic imaging services responsive?

Good

We had not previously rated this service. We rated it as **good.**

Service delivery to meet the needs of local people

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

The service was located near to the centre of a town with access via public transport. There was lots of free parking on the roads surrounding the clinic.

The clinic was located on the ground floor and consisted of a reception area, (which was also where the women chose their keepsake scan pictures and could also buy novelty gender reveal items), which then led to a corridor which the scanning room was located on, leading through a kitchen area with toilet and baby changing facilities at the back of the building. Everything within the service was easily accessible for wheelchair users and those with prams and push chairs.

In the scanning room there was an ultrasound machine, a bed for the women to lie on whilst having their scan and several chairs for partners and other relatives to sit on. There was a large raised screen on the wall directly in front of where the women would lie for their scan, so they had clear sight of their baby.

The service was flexible in meeting clients' needs, offering appointments after working hours during the week and at weekends.

Meeting people's individual needs

The service took account of people's individual needs.

Staff told us that there was no provision of information in any language other than English. Staff said they would be happy for clients' friends or family members to attend appointments to translate, if required. This was not in line with best practice guidance, however, staff acknowledged that this would not be ideal. Staff told us that they had never had anyone attend the service who was not English-speaking.

We were told that for deaf people, clients could use the loop system.

The toilets had baby change facilities.

Access and flow

People could access the service when they needed it.

Women could arrange an appointment over the phone seven days a week.

The service was by appointment only, to minimise waiting times. Although some of the appointment times had run over, staff kept clients up to date and apologised when they were behind. However, every woman still got her allocated time for her scan.

Learning from complaints and concerns

The service treated concerns and complaints seriously, and had systems in place to investigate them and learn lessons from the results, and share these with all staff.

The service had a complaints policy which we reviewed. The policy detailed what to do if someone raised a

complaint and this detailed that the service aimed to resolve the complaint quickly within three working days. It also referred to CQC being notified for more serious complaints. We saw no evidence of a review date on the policy, but we had been told every policy was reviewed each year. The policy detailed that a written acknowledgement would be sent to the complainant within two working days and that there would be a full response within 14 working days.

The service told us that between January 2018 and January 2019, there were two complaints received by the service, both of which had been managed under their formal complaints procedure. We had sight of both complaints, one of which was not the fault of the service and the other one was also unavoidable, but both complainants were offered free return scans.

We saw that the service actively encouraged clients to provide feedback and raise any concerns they might have. Clients or their representatives could provide feedback, raise a concern, or formally complain in person, by telephone, or by email or letter. Any learning taken from complaints was shared with staff as part of the learning process.

Are diagnostic imaging services well-led?

Requires improvement

We had not previously rated this service. We rated it as **requires improvement.**

Leadership

Managers in the service had the skills and abilities to run an effective service.

The company had three directors, with one being a sonographer, as well as another three qualified sonographers, two of which were also midwives. The service was overseen by the registered manager, who was also one of the directors. A registered manager of a provider manages the regulated activity carried out at the service. The registered manager had been in post for over eight years.

The staff all worked closely as a team and ensured there was effective communication amongst all the staff members.

Vision and strategy

The service had a vision for what it wanted to achieve.

The service had originally been set up by a group of mums who provided parents with a memorable keepsake of their pregnancy through offering high quality professional images of their unborn baby.

We saw the service regularly sought feedback from clients and acted on suggestions made by them.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The service worked closely as a team and tried to promote an effective and supportive culture. Most of the team had been in post for several years, with the newest member having joined in 2016.

The staff used a communication book to relay messages to each other, as they all worked different days.

We saw evidence of a diversity and inclusion statement and policy in relation to staffing. The policy related to the Equality Act 2010 and we saw this to be in date.

Staff were passionate about the service they delivered, but also ensured women were also aware of the importance of attending for all their routine hospital appointments.

Governance

The service used a systematic approach to continually improve the quality of its services. However, the service did not have robust systems to meet the fit and proper persons regulations.

The registered manager took the lead for governance. Staff were clear about their roles and understood their responsibilities. However, on asking, staff files did not contain much information, other than the hours each staff member worked.

The service had a recruitment policy which detailed that as part of the recruitment process, they would keep a copy of the passport, any relevant qualifications and they would review registrations as appropriate. However, the service could not provide us with the information it had checked when staff had started their employment. The

policy stated that references and the disclosure and barring service check would be completed if the individual was not employed by an NHS trust for the same role. This meant that the service had no evidence of these checks having been completed for staff employed by the NHS. The service did not have a policy for the assessment of the fitness of directors or provide us with evidence of how the directors were fit and proper.

The service could not provide a copy of the information listed in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for staff or directors which is a requirement of Regulations 19 and 5 respectively. This includes information such as proof of photographic identity, disclosure and baring services checks, references and a full employment history with a satisfactory explanation for any gaps.

The registered manager told us that there were regular monthly meetings held with the directors to discuss any changes needed and other staff would be updated accordingly.

We were told that policies were reviewed on a yearly basis, however some of these policies did not have review dates on them to evidence this. The policy relating to safeguarding was dated 2013 and had not been updated since.

Managing risks, issues and performance

The service had systems in place to identify and manage risks.

There were up to date risk assessment, and health, safety and environment policies and procedures in place.

Managing information

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The service would upload any paper copies of consent, or other detail to the computer system and would then ensure that any paper copies were destroyed safely and effectively.

Records were stored securely. The service was paper light and mainly used a secure electronic database to create and share client information. Where paper was used, the completed form was scanned onto the client electronic record then securely destroyed.

Engagement

The service engaged well with clients and staff to plan and manage services.

Women and their partners could also have their baby's heartbeat recorded during the scan as a keepsake. The service had started to offer this based on feedback.

The service had feedback forms which were available for clients to complete and staff embraced any feedback given and had acted on feedback they had received, particularly in relation to heartbeat recordings.

One of the women who had previously attended for a scan at the service, had started making gender reveal balls for clients to purchase.

Learning, continuous improvement and innovation

The service engaged well with clients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The service was committed to improving services by learning from when things went well or wrong and from listening to client feedback. After receiving feedback from some clients requesting a recording of the baby's heartbeat, the service introduced this. Another example was one of the clients made a keepsake item and as the service liked this so much, the client now makes these regular for sale in the clinic.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure there is an effective selection and recruitment procedure and that the appropriate checks for directors are being completed.
- The provider must ensure there is an effective selection and recruitment procedure and that the appropriate checks for employees are being completed.
- The provider must develop and update the safeguarding training and policy to align with current guidance. The provider must ensure that they are able to evidence that staff have attended mandatory safeguarding training.

Action the provider SHOULD take to improve

- The provider must ensure that all policies are reviewed on a regular basis and have clear review dates evidenced.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors The provider did not ensure there was an effective selection and recruitment procedure and that the appropriate checks for directors were being completed

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider did not ensure there was an effective selection and recruitment procedure and that the appropriate checks for employees were being completed

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider could not be assured that staff had received the appropriate safeguarding training