Mrs Jennifer Hodkinson

Jen Hodkinson (Catch a Glimpse)

Inspection report

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Date of inspection visit: 25 May to 26 May 2022
Date of publication: 25/07/2022

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?	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 have not previously rated this location. We rated it as good because:

- Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff kept equipment and the premises visibly clean. Staff completed and updated risk assessments for each woman and removed or minimised risks. 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. Staff kept detailed records of women's care and treatment.
- The service provided care and treatment based on national guidance and evidence-based practice. Staff worked together as a team to benefit women. They supported each other to provide good care. Key services were available to support timely care for women. Staff supported women to make informed decisions about their care and treatment.
- Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to women, families and carers to minimise their distress.
- The service planned and provided care in a way that met the needs of local people and the communities served. People could access the service when they needed it and received the right care promptly. It was easy for people to give feedback and raise concerns about care received.
- Leaders had the skills and abilities to run the service. They were visible and approachable in the service for women and staff. The service had a vision for what it wanted to achieve. Staff felt respected, supported and valued. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Leaders and staff actively and openly engaged with women, staff, and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women.

However:

- The service did not provide mandatory training in key skills to all staff. This meant that some staff working in the service did not have up to date training in key skills.
- Staff could not demonstrate that they monitored the effectiveness of care and treatment. They could not demonstrate that they used the findings to make improvements and achieved good outcomes for women.
- The service was not always inclusive and did not always take account of women's individual needs and preferences.
- Leaders did not always operate effective governance processes. Managers had limited systems to manage risks. There was limited recognition and escalation of relevant risks and issues and identified actions to reduce their impact. We saw limited examples of continuous learning and improvement of the service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Good 	We rated this service as good overall because we rated safe, caring and responsive as good. We do not rate the effective domain in diagnostic and screening services. We rated well led as requires improvement. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Page

Background to Jen Hodkinson (Catch a Glimpse) 5

Information about Jen Hodkinson (Catch a Glimpse) 5

Our findings from this inspection

Overview of ratings 7

Our findings by main service 8

Summary of this inspection

Background to Jen Hodkinson (Catch a Glimpse)

Jen Hodkinson (Catch a Glimpse) is operated by Mrs Jennifer Hodkinson. Jen Hodkinson (Catch a Glimpse) registered with the Care Quality Commission in 2019. The service has had a registered manager in place since initial registration.

The service provides a range of ultrasound scans including transvaginal scans in 2D, 3D and 4D during pregnancy for women aged 18 years and over. The service is registered to provide the regulated activity of diagnostic and screening procedures.

All scans were performed by the registered manager and a locum sonographer. The registered manager and locum sonographer also worked as sonographers in a local NHS trust.

We have not previously inspected this service.

How we carried out this inspection

Our inspection was announced at short notice to enable us to observe routine activity. We inspected this service using our comprehensive inspection methodology. Two inspectors carried out the inspection on 25 May and 26 May 2022 with off site support from an inspection manager.

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

During our inspection we spoke with three members of staff including the registered manager, practice manager and client relations lead. We observed two ultrasound scan procedures with the women's consent, spoke with five women about their experience of the service and reviewed feedback of previous service users on an online feedback platform. We reviewed a range of policies, procedures and other documents relating to the running of the service including consent, referral and scan reports. We reviewed three staff records. We also reviewed the centralised appointment system.

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.

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:

Summary of this inspection

- The provider must have effective governance processes to ensure they assess, monitor and improve the quality and safety of the service. This includes developing an effective system to monitor compliance with mandatory training. (Regulation 17)

Action the service SHOULD take to improve:

- The service should ensure arrangements for managing clinical waste keep people safe.
- The service should do everything reasonably practicable to make sure the service meets women's needs and reflects their personal preferences.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Diagnostic and screening services

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

Are Diagnostic and screening services safe?

Good

We rated it as good.

Mandatory training

The service did not provide mandatory training in key skills to all staff. This meant that some staff working in the service did not have up to date training in key skills.

Mandatory training was delivered through e-learning; however, the service did not have a mandatory training matrix or policy meaning we were unable to determine which training modules were classed as mandatory for each staff role. We were told that all staff were required to complete online safeguarding training and we saw evidence of this in the staff records we reviewed.

Two out of four staff members had not completed training in infection prevention and control, health and safety and equality and diversity. Not all staff members had completed fire safety training.

The registered manager who was also the sonographer for the service and locum sonographer had both completed a mix of online and face to face training which was comprehensive and met the needs of women and staff.

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 training specific for their role on how to recognise and report abuse. All staff had completed level two safeguarding adults and children training. The registered manager had completed level three safeguarding adults and children training. The registered manager was the safeguarding lead for the service.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff understood their responsibilities if they identified women who had undergone female genital mutilation (FGM). Staff told us that FGM was covered in the safeguarding training modules.

Good

Diagnostic and screening services

Information relating to the six principles of safeguarding were displayed throughout the clinic. The service had a toilet for pregnant women only and there was safeguarding information displayed allowing women to seek the necessary support.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a safeguarding referral form and the safeguarding policy provided key contact details. However, the service had not reported any safeguarding incidents since they had opened in 2019.

The clinic required all staff to have a Disclosure and Barring Service (DBS) check as part of their recruitment process. Three staff files were reviewed, and all staff had their DBS check.

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 clean and had suitable furnishings which were clean and well-maintained. We observed staff cleaning all areas of the clinic between appointments.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The service carried out weekly deep cleans and there were records for the deep cleaning checklist completed and signed for the past 12 months.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were bare below the elbow when required. We observed the registered manager wore gloves and an apron whilst scanning women. Staff cleaned equipment before and after contact with women.

Staff correctly cleaned and disinfected the transvaginal probes to reduce the risk of cross infection following good practice guidelines. There was a choice of latex and latex free probe covers for those with an allergy.

We observed women and visitors to the clinic being encouraged to wear masks and sanitise their hands-on entry to the clinic. Face masks, hand sanitiser and a waste bin were available at the reception and waiting area.

There were no handwashing facilities in the scan room, however these were available in the toilet facility adjacent to the scan room. We observed the registered manager washing their hands and use hand sanitiser between each scan appointment. Handwashing posters were displayed above all wash basins in the clinic.

The service carried out hand hygiene audits every three months. They had achieved 100% compliance for the 12 months before our inspection.

Two staff members had not completed any infection prevention and control training.

Environment and equipment

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

The service had suitable facilities to meet the needs of women and their families. The design of the environment followed national guidance. The scanning room enabled privacy and conversations could not be overheard.

Good

Diagnostic and screening services

There was a reception area where women were greeted, a waiting area close to the reception with a couch and a further waiting area down the corridor with multiple single seats, a scanning room, staff kitchen, women's toilet, store cupboards and a viewing room where women and loved ones could choose their photographs.

The clinic provided a screen for women to change behind if they had a transvaginal scan to maintain privacy and dignity.

The scanning room was large and spacious and could accommodate up to five people including the woman, the sonographer and the scan assistant. There was a large screen for women and families to view images from any seating area, an adjustable examination couch and ultrasound scanning machine. The scanning room also had gender reveal lighting around the ceiling. The service played relaxing music in the reception area and scanning room to help calm women attending their appointments.

Staff carried out daily safety checks of specialist equipment. The registered manager ensured the maintenance and service of the ultrasound scanning machine was carried out through a contract with an external company. Staff were required to complete a daily health and safety checklist which covered tasks such as electrical equipment checks, slip/trip hazards and ensuring staff were aware of evacuation procedures and assembly points.

However, staff did not always dispose of clinical waste safely. The registered manager told us that clinical waste was stored in a clinical waste bin in the scanning room; the bin was not labelled to indicate that it was for clinical waste only. Clinical waste was collected as part of the general waste by an external company.

We saw items which were subject to the Control of Substances Hazardous to Health (COSHH) regulations, for example cleaning solution, which was not in a locked cupboard in the staff kitchen.

Assessing and responding to women's risk

Staff completed and updated risk assessments for each woman and removed or minimised risks. Staff identified and quickly acted upon women at risk of deterioration.

When women arrived at the clinic for their appointment, they were asked to complete a medical history form electronically which was reviewed by clinic staff and sent to the sonographer for review prior to the scan. For example, women were asked whether they had any abdominal pain and/or bleeding or whether they had any allergies. Any risks identified on the medical history form were flagged on the online system.

Staff knew about and dealt with any specific risk issues. The service had a referral process for staff to follow if any abnormalities were found on an ultrasound scan. We observed staff making a referral to the local early pregnancy unit, with the woman's permission. Referral information was added to a comment section on the scanning report which was given to women to take to the hospital. We saw evidence of where the service had followed up referrals with the hospital to ensure they had been made correctly.

The service had exclusion criteria which all staff understood. For example, all staff were clear that they did not offer scans to anyone under the age of 18. We were told that the service would not scan women who had been scanned within the last two weeks. However, this was not documented in a policy or on the provider website.

The terms and conditions outlined on the service consent form and information available on the service website recommended service users to continue to attend NHS appointments and scans.

Good

Diagnostic and screening services

Staff knew how to deal with emergencies if they were to arise. Staff said that they would contact emergency services if required. The registered manager had completed level two maternal resuscitation, level two new-born resuscitation and level three adult resuscitation training. Three staff members were trained in first aid.

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.

The service had enough staff to keep women safe. The service had four staff members; one full time sonographer who was also the registered manager, one locum sonographer, a practice manager and a client relations lead. The locum sonographer worked at the clinic one day per month. The registered manager and locum sonographer also worked as sonographers in a local NHS trust.

We were told the service was in the process of recruiting a receptionist due to the practice manager leaving the service. There were plans in place for the client relations lead to step into the practice manager role.

The registered manager told us if they were off due to sickness absence, staff would contact women offering them to either reschedule their appointment or offer a refund. Any other staff absence was covered by the practice manager or client relations lead.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Women's notes were comprehensive, and all staff could access them easily. Women's records such as consent and scan reports were stored on an electronic system which could be accessed by all staff.

The electronic system alerted the registered manager to any identified risks from the medical history form completed by women on their arrival to the clinic. In the records we reviewed, we saw evidence of discussions between the registered manager and women.

Staff prepared scan report templates 24 hours in advance to help appointments run smoothly and on time.

Records were stored securely. Scan reports and women's details were retained for 12 months on a secure online system. We were told that scan images were stored electronically for three to four months, however this was not outlined in the provider general data protection regulation (GDPR) policy.

Medicines

The service did not store or administer any medicines to service users.

Incidents

Staff recognised and reported incidents and near misses. When things went wrong, staff apologised and gave women honest information and suitable support.

Staff knew what incidents to report and how to report them. The service had a serious untoward incident report form for recording incidents, actions and outcomes from incidents. However, the registered manager told us the service had not had any incidents over the past 12 months.

Good

Diagnostic and screening services

Incidents relating to women, for example referrals to the early pregnant unit were recorded on the electronic patient record system.

Staff understood the duty of candour. They were able to articulate how to be open and transparent and gave women and families a full explanation if and when things went wrong.

The service had a duty of candour policy.

However, the service did not have an incident reporting policy.

Are Diagnostic and screening services effective?

Inspected but not rated

We do not rate effective in diagnostic imaging services.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff could access policies and national guidance online or on a noticeboard in the clinic. All the policies we reviewed were in date and the registered manager told us that they were reviewed annually.

Sonographers at the clinic followed national guidance from the British Medical Ultrasound Society (BMUS), Royal College of Obstetricians and Gynaecologists (RCOG), Department of Health and Social Care (DHSC) and National Institute for Health and Care Excellence (NICE).

Sonographers followed guidance and recommendations from BMUS, as low as reasonably achievable (ALARA) principle, they used the lowest possible output power while also keeping scan times as short as possible which still allowed to gain correct and required results.

Nutrition and hydration

Staff gave women appropriate information about drinking water before the ultrasound scans to ensure the sonographer could gain a better view of the baby.

Women could purchase drinks from the clinic.

Women's outcomes

Staff could not demonstrate that they monitored the effectiveness of care and treatment. They could not demonstrate that they used the findings to make improvements and achieved good outcomes for women.

We spoke with the registered manager about the monitoring of outcomes. There were no formal service level targets or performance indicators. Waiting times, scan times, rescan rates and gender inaccuracies were not reviewed to monitor the effectiveness of the service.

Good

Diagnostic and screening services

The registered manager told us that the sonographers received peer reviews in their NHS role. There was no peer review process within the service.

Competent staff

The service made sure staff were competent for their roles. The registered manager appraised staff's work performance to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. The registered manager was an experienced NHS sonographer and midwife who was registered with the Nursing and Midwifery Council (NMC) and continued to work in the NHS. The service locum sonographer was Health Care Professions Council (HCPC) registered.

The manager supported staff to develop through yearly, constructive appraisals of their work. However, one staff member had not had a recent appraisal.

Staff we spoke with told us they received a full induction; however, we saw no evidence of induction checklists during our inspection.

There was no evidence that training needs were identified through regular observations, or supervision. The staff members annual appraisals and discussions was the only time staff had their competencies checked. However, we were told that the practice manager had been trained in dealing with complaints and providing information to the early pregnancy unit during the referral process.

Multidisciplinary working

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

Each scan was carried out by a sonographer with assistance from the practice manager or client relations lead. We observed staff working well together to reassure women, take consent and record accurate notes for the scan report.

We observed good teamwork between all staff during our inspection.

The service had processes for sharing information with local NHS trusts when women were referred, following concerns being detected. The service had made 33 referrals to the hospital since January 2022.

Seven-day services

Key services were available to support timely care for women.

The service offered scans four days a week, including weekends and evenings. It had flexible opening hours dependent on the availability of the sonographer and the appointments booked.

Women could book appointments 24 hours a day through the website or text messaging service.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in clinical areas.

Good

Diagnostic and screening services

The service provided a range of free literature advising on conditions in pregnancy and details of external services that may provide health promotion.

We observed posters in the bathroom providing health promotion such as domestic abuse help and advice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. However, not all staff had completed training on the Mental Capacity Act.

Staff gained consent from women for their care and treatment in line with legislation and guidance. We observed the registered manager confirm the women's identity by asking name, date of birth and checked that they had consented to the scan before they proceeded.

Staff clearly recorded consent in the women's records. Women completed consent using a computer which saved directly to their electronic record. During our inspection we reviewed six records. Consent had been obtained and documented correctly where appropriate.

The service had a separate consent form for transvaginal scans.

However, the service did not have a Mental Capacity Act policy.

Are Diagnostic and screening services caring?

Good

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.

During our inspection we observed staff introduce themselves, explained their roles, provided details of the procedure and welcomed any questions.

We saw staff caring for women with compassion and feedback from women confirmed that staff treated them with kindness.

Good

Diagnostic and screening services

Staff kept women's care and treatment confidential. The scans we observed were reassurance scans and the women had chosen not to find out the gender at the time of the scan. We saw that staff supported this decision and worked to ensure that the gender was not revealed.

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs.

The practice manager and client relations lead chaperoned women who came for a scan.

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.

Staff supported women who received bad news and demonstrated empathy when having difficult conversations. During our inspection, we observed all staff supporting a woman and after they had received bad news. Staff asked the inspection team to sit in a side room to respect the privacy and dignity of the woman.

Staff understood the emotional impact of the scan on women and on those close to them. The registered manager provided reassurance during the two scans we observed. They provided details of every step of the procedure and invited questions. They confirmed that the babies were healthy and offered words of encouragement throughout.

Staff were able to explain the procedure when abnormalities or concerns were detected. The sonographer would inform the woman what they had seen and that they were going to refer them to an NHS early pregnancy unit. The sonographer or practice manager would make the referral and the woman and family could stay in the scanning room for as long as they wanted.

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.

Staff made sure women and those close to them understood their care and treatment. The service offered various scan packages and this information was displayed in the clinic and on the website so that women could choose which package they wanted.

Staff talked with women, families and carers in a way they could understand. The registered manager described the ultrasound images on the screen to different family members. For example, taking time to show family members the babies body features.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. Feedback was provided via a text messaging service and on social media. The text messaging service used a scoring system with one being the lowest and five being the highest.

Good

Diagnostic and screening services

Women gave positive feedback about the service. Data from the text messaging feedback service showed that for the period between January 2022 and April 2022 the service received a total of 66 responses with a score of five. We also reviewed comments for the past 12 months on social media. Positive comments were made about the welcome, the kindness and caring of staff and the cleanliness of the clinic. We saw examples of cards the clinic had received praising staff.

Are Diagnostic and screening services responsive?

Good

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 the services, so they met the changing needs of the local population. The service offered scan appointments at evening and weekends to accommodate the needs of people who worked Monday to Friday.

Facilities and premises were appropriate for the services being delivered.

The clinic was easily accessible by public transport and there was on-site parking with additional parking in nearby streets.

Staff monitored and took action to minimise missed appointments. A weekly report was produced to record the did not attend appointments.

Meeting people's individual needs

Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers. However, the service was not always inclusive and did not always take account of women's individual needs and preferences.

The clinic was located on the ground floor, with the main entrance at street level. The premises were fully accessible and had an accessible toilet.

The service had access to a telephone interpretation service to communicate effectively with women whose chosen language was not English. However, staff told us they had never had to use this service.

Staff told us that any additional needs for women or visitors were discussed or considered at the time of booking.

The examination couch was fully adjustable and able to accommodate bariatric women.

Good

Diagnostic and screening services

The service offered a range of baby keepsake and souvenir options which could be purchased at the time of their scan. These included photographs, videos of their scans and heartbeat bears (the sound of a woman's unborn baby' heartbeat placed inside the teddy bear).

However, the service did not have a policy for equality, diversity and inclusion. Not all staff had received training in equality, diversity and inclusion.

The service did not have a policy which outlined how the service adapts to and met the needs of those with mental health needs or learning disabilities. However, women were able to disclose any mental health needs or learning disabilities on the medical history form.

The service did not have facilities to meet the needs of people with sight or hearing problems. There was not a hearing loop and no information available in accessible formats.

Access and flow

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

Women were able to book their appointment by telephone or on the website at a date and time to suit them, including same day appointments.

Each appointment had 30 minutes allocated to it. Staff we observed did not rush the woman and took their time when discussing information.

Staff flexed appointments to allow for rescans to take place quickly where they were needed if the sonographer was unable to obtain a clear image due to the position of the baby.

Staff supported women when they were referred or transferred between services. The service directed women under the age of 18 years to a clinic where they offered scans for women aged 16 and over.

Staff supported women when they were transferred to local early pregnancy units.

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 areas of the clinic. Women were directed to raise their concerns in the first instance to the practice manager or the registered manager.

Staff understood the procedure on complaints and knew how to handle them. The complaints procedure included clear escalation for women to follow if they were dissatisfied with the outcome, including contact details for the practice manager.

Complaints were documented in women's individual records online. There had been three complaints in the last six months, and these were resolved within the timescales specified in the provider complaints procedure.

Good

Diagnostic and screening services

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, there was an additional cost for transvaginal scans and a woman had complained to the service because she was not made aware of this prior to the scan. The service acknowledged this complaint and added information to the transvaginal ultrasound consent form informing women of the additional cost.

Are Diagnostic and screening services well-led?

Requires Improvement

We rated it as requires improvement.

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.

The service had the same registered manager in place since it first registered with the CQC in September 2019.

Staff told us the registered manager was supportive, visible and approachable. Throughout the inspection, we saw the registered manager speaking with and supporting staff and women using the service.

Staff told us that they were supported to develop both personally and professionally if they chose to by the registered manager.

Vision and Strategy

The service had a vision for what it wanted to achieve. Leaders and staff understood and knew how to apply this.

The registered manager described the clinics '5-star core values'. These were; friendly and welcoming, kind and compassionate, respectful and considerate, listening and learning and personalised service. Staff we spoke with were able to describe these values and they were displayed throughout the clinic.

The registered manager had a strategy which included both short- and long-term goals. These included; increasing the numbers of scans provided per month, larger premises and franchising the business.

Culture

Staff felt respected, supported and valued. They were focused on the needs of women receiving care. The service had an open culture where women, their families and staff could raise concerns without fear.

Staff that we met during our inspection told us they felt respected, supported and valued.

All staff spoke passionately about the service and were focused on providing high quality, compassionate care to women.

The service had explored ways of supporting baby reveals that did not focus on specific genders, such as introducing pregnancy announcement boards.

The service had a whistleblowing policy in place and staff we spoke with described how they could raise concerns and told us they felt safe to do so.

Governance

Staff at all levels were clear about their roles and accountabilities. However, leaders did not always operate effective governance processes.

The registered manager had overall responsibility for governance and monitoring the service performance. Policies and procedures were available to staff online and were all within their review date.

We reviewed three staff records at the service. Each staff member had a disclosure and barring service check (DBS) and sonographers were appropriately trained healthcare professionals. We saw a copy of a consultant agreement between the service and the locum sonographer. The service had a recruitment policy.

Staff knew their roles and responsibilities and all staff including the registered manager were clear what they were accountable for.

The service had liability insurance in place.

Leaders did not always operate effective governance processes. For example, the service did not have an effective system to monitor staff mandatory training. We saw items which were subject to the Control of Substances Hazardous to Health (COSHH) regulations, for example cleaning solution, which was not in a locked cupboard in the staff kitchen.

The service did not have an incident reporting policy.

The service completed checks to monitor the safety of the service. However, there was limited evidence to demonstrate the effectiveness of care and treatment and outcomes for women.

We were told that team meetings were held monthly, however the service was only able to provide us with meeting minutes from three meetings in the past 15 months.

Management of risk, issues and performance

Managers had limited systems to manage risks. There was limited recognition and escalation of relevant risks and issues and identified actions to reduce their impact.

The service did not hold a risk register; therefore, we were not assured that the registered manager had oversight of risks.

We saw that there was limited monitoring of performance through audit activity. Managers did not always review their performance or collate data to enable to understand how they could make improvements.

The service utilised their own feedback system which involved liaising with other clients about their services at other clinics.

To reduce the risks of lone working there was a lone worker policy which stated that were possible situations where lone members of staff are at the premises alone should be avoided as much as possible. The service had a panic alarm and a smoke security alarm. Any alerts would be directed to an external company.

The door to the service was locked at all times and entry was controlled by staff members only.

Information Management

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.

The clinic had a policy for the storage of online records which staff followed. All scan reports and other confidential information could be accessed from laptops and computers in the clinic through a secure server. Access to laptops, computers and online systems was password protected.

Women were able to receive their scan images digitally through a secure encrypted email system. The secure encrypted email system was also used to send scan images to the hospital when women had been referred.

However, the service did not collect or analyse any performance data, such as rescan rates and gender accuracy data.

Not all staff had completed information governance training.

Engagement

Leaders and staff actively and openly engaged with women, staff, and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women.

The registered manager engaged proactively with staff to involve them in service improvements. Staff told us they were actively encouraged to make suggestions to improve the service. For example, the introduction of pregnancy announcement boards.

The service actively encouraged feedback from women and families. Staff contacted women who submitted a score of three or below via the text messaging feedback service to gather information to help improve the service.

Women we spoke with told us that the information they received during their scan was clear and they were able to ask the sonographer questions.

The clinic participated in raising money for local charities.

The service maintained regular contact with local NHS providers to ensure referral pathways were in place for women who needed them.

Learning, continuous improvement and innovation

We saw limited examples of continuous learning and improvement of the service.

Staff and managers did not undertake training in quality improvement therefore, the opportunity to identify areas for improvement was limited.

Performance data was not collected and made available to staff to enable them to change or improve practice.

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 17 HSCA (RA) Regulations 2014 Good governance The provider must have effective governance processes to ensure they assess, monitor and improve the quality and safety of the service. This includes developing an effective system to monitor compliance with mandatory training. (Regulation 17)