PPU Enterprises Limited

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Inspection report

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

Ratings

Overall rating for this location	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?	Good

Summary of findings

Overall summary

We rated it as good because:

- The service had enough staff to care for women and keep them safe.
- Staff had training in key skills, understood how to protect women from abuse, and managed safety 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.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of women.
- Staff treated women with compassion and kindness. They respected their privacy and dignity. 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.
- Women could access the service when they needed it and did not have to wait 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 applied 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 to plan and manage services and staff were committed to improving services continually.

However:

- Information leaflets were not available in other languages or in an accessible format.
- For women who lacked capacity, the policy to gain consent did not follow national guidance as services offered would not be medically indicated.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to PPU Enterprises Limited

PPU Enterprises aka Hey Baby 4D Southampton, is a baby scanning service located at the Ageas Bowl in Southampton. The service is based in a standalone unit which it shares with a physiotherapy service.

The service offers private pregnancy scanning services and primarily serves the communities of Southampton and Eastleigh; however, it also allows bookings from women from outside this area. The service provides ultrasound scans for reassurance or gender determination from 6 - 42 weeks of pregnancy. Appointments include scan findings and images for keepsake purposes. In the event of anomaly detection, women are referred to the local NHS early pregnancy assessment unit or maternity service, depending on the stage of pregnancy. The service also provides non-invasive pregnancy testing (NIPT). NIPT is a screening test used to determine the risk of a child being born with certain chromosomal abnormalities.

The service registered with CQC in 2019. The service has had the same registered manager in post since registration. This is the service's first inspection since their registration with CQC.

We carried out this unannounced inspection using our comprehensive inspection methodology on 3 September 2021.

We rated all services inspected as good. Overall, we rated safe, effective, caring, responsive, and well-led as 'good'.

How we carried out this inspection

During the inspection we spoke with 7 staff, reviewed 8 patient records and patient feedback from the previous twelve months.

You can find further 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:

- The service managed woman's referral's themselves and took responsibility for them. This ensured a consistent approach to all referral's and enabled oversight that all potential anomaly findings were communicated to the woman's maternity provider.
- The service seriously considered the impact a potential failed pregnancy or anomaly finding during a scan could have on a woman and their family. They planned their services in a way to reduce distress and have developed simple scanning room exit policies to avoid additional distress.
- The service applied a blanket policy of referring all women who conceived before the age of consent to safeguarding authorities. This meant supportive services could identify and make direct contact with the women, in some cases in advance of her presenting to NHS maternity services. This also reduced the risk of young women with concealed pregnancies being unknown to NHS maternity providers.

Summary of this inspection

Areas for improvement

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 SHOULD take to improve:

- The service should ensure national mental capacity guidance is followed when requesting consent from women who cannot consent for themselves and consider the appropriateness of offering the procedure in such a case. (Regulation 11)
- The service should consider providing patient leaflets in accessible formats and languages other than English.
- The service should consider how to use established translation systems and processes more to provide support to women whose first language is not English rather than referring to family members.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Diagnostic imaging

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

Are Diagnostic imaging safe?

Good

Mandatory training

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

Sonographers and administrative staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of women and staff. Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia. All staff had training in key areas such as hand hygiene, health and safety, safeguarding, mental capacity and deprivation of liberty. Staff employed in administrative non-medical roles also undertook additional training in data protection.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers had oversight of training completion and when training was due to expire. The target for completion was set at 100% and we saw this had been met.

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. There was mandatory training for all staff. All staff were trained to a level in adult and child safeguarding suitable to their role.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were clear on their roles and things that may raise concerns. They were able to explain the process they would follow for escalating safeguarding concerns.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding referrals were completed by management who followed up all referrals with the local authority. We saw that the service had sent referrals, and these had been acknowledged by the local authority. The service offered pregnancy scanning services from the age of 13 and had a policy to refer all clients who had conceived under the legal age of consent.

Good

Diagnostic imaging

Staff followed safe procedures for children visiting the service. Children were able to attend as part of a family group; clients were advised on booking that children should remain outside the scanning room until positive health of the foetus was confirmed.

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. Staff told us that communal and clinical areas were cleaned daily. Clinical areas were given an additional deep clean weekly.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. This was monitored by managers and we saw records of this.

Staff followed infection control principles including the use of personal protective equipment (PPE). There was signage to support good hand hygiene and PPE was readily available. We saw that staff were bare below the elbow and washed their hands in line with infection prevention and control (IPC) policies. We saw evidence that observation of IPC measures was undertaken and monitored by managers.

Staff cleaned equipment between patients and records were completed following routine cleaning. Sonographers cleaned the ultrasound machine after every use and at the end of a session and we saw staff doing this. Staff we spoke with also told us the steps they would go through to clean the machine following a scan, and this supported good infection prevention.

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 some safety checks of specialist equipment. Sonographers checked equipment was in working order at the beginning of scanning sessions, but no formal quality checks were undertaken. Scanning equipment was serviced annually by the manufacturer, they also attended if there was equipment failure or fault. Managers told us that engineers would attend within a day of a fault being reported or in some circumstance's replacement equipment would be dispatched directly to the service.

There was a fire evacuation policy in the waiting area and staff were informed of this policy during induction. The service also told us if changes were made to fire safety policies staff would be updated immediately.

The service had enough suitable equipment to help them to safely care for women. The service had a single scanning machine which was used for all scans. The couch could be raised and reclined for the woman's comfort and if scanning required repositioning.

There was also a specialist chair for sonographers that supported good ergonomic positioning when scanning and reduced the risk of repetitive strain injury. Repetitive strain injury is a common workplace injury for sonographers due to the precise and repeated hand movements made during scanning.

Non-invasive prenatal testing was carried out at the desk where testing equipment was disposed of into a disposable bowl.

Good

Diagnostic imaging

Staff disposed of clinical waste safely. There were clinical waste bins and we saw that waste was correctly segregated. The service shared external clinical waste bins with another service, and we saw these were locked to restrict access. Managers told us this waste bin was emptied weekly.

The service used sharps bin for blood testing for NIPT, this was stored on a trolley in the scanning area. However, during our inspection the sharps bin was not closed or labelled in line with national guidance. The safe use and disposal of sharps using these bins reduces the risk of injury and the acquisition of blood-borne viruses (BBVs) to staff, women and their families.

The design of the environment followed national guidance. The scanning room enabled privacy and conversations could not be overheard. There were curtains that would be closed if a transvaginal scan was indicated. Window blinds had been installed to reduce glare during scanning in response to staff feedback.

The service was wheelchair accessible. The reception area was small and shared with another service. The service had made changes to the waiting area due to Covid-19 guidance. There was no indoor waiting area however, an outdoor seating was available under a sheltered awning.

The service offered a large car parking area and women could wait inside the vehicles until the sonographer was ready to scan them. However, if this option was not available, woman would wait outside until their appointment. The service recognised the need for an internal waiting area and told us that they were converting an area of the building into an internal waiting area. Feedback from some women had also highlighted the need for an internal waiting area.

During our inspection we saw a cupboard that contained retail items and clinical equipment was untidy and cluttered and did not enable users to find items easily. Equipment for NIPT screening was also stored in this cupboard. The layout of the cupboard meant that oversight of clinical and retail stock was limited. Following feedback on the day the service supplied evidence to show they had made changes to this area to improve organisation and oversight.

Assessing and responding to women 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 completed some risk assessment for each woman on arrival. Woman attending for scans were advised at the point of booking and on attendance that scans were non diagnostic, and to still attend NHS scans and appointments. Informed consent forms outlined the limitations of the scans relating to anomaly diagnosis, maternal health and gender of the foetus. Informed consent is a process used to inform a person of the benefits and risks of a healthcare intervention in advance, this allows them to decide whether to give consent based on the facts presented to them. Woman could read the details on their informed consent form in advance of attending the clinic.

Women completed an informed consent form that provided an area to detail allergies. Administrative staff checked the forms before scanning commenced and made the sonographers aware of any allergy details.

If all wellbeing checks could not be completed during the initial appointment, sonographers rebook patients to complete the scan or could arrange a referral or a refund. We heard how patient appointments would also be rebooked if medical reasons prevented them from attending. Managers monitored patient bookings to ensure exposure to ultrasound scans was a low as reasonably possible.

Good

Diagnostic imaging

Staff responded promptly to any sudden deterioration in a women's health. Sonographers told us they were clear on referral policies for referring medical emergencies, such as ectopic pregnancies and had used them. Staff were able to discuss the steps they would take if a woman needed emergency healthcare. There were security staff on the main arena site who would bring defibrillation equipment if this was required.

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 and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank locum staff a full induction.

The service had enough sonographers and support staff to keep women safe. The service employed a mixture of substantive and bank staff. There were sufficient numbers of staff meaning that staff sickness could be covered at short notice. Managers were able to cover the role of administrative staff when needed and the service told us they had not had a situation where staff shortages led to cancellation of patients.

Managers made sure all staff had a full induction and understood the service. All staff completed an induction period of three months and were given an employee handbook. Bank staff were managed in house and not through an external service. Bank staff employed in the service had undertaken a full induction and were familiar with the procedure of the service.

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 records were comprehensive, and all staff could access them easily. All staff had access to an electronic records system that they could all update. Staff used electronic scanning to store consent forms and some notes. Staff always had access to informed consent forms and wellbeing paperwork during the scanning process. The service had developed a standardised electronic scanning record to reduce paper used and make the completion of the form easier for the sonographer as this could be completed during the scan without needing additional equipment. We reviewed eight patient records and saw they contained relevant information and were fully completed.

Records were stored securely. Paper copies were also retained in a locked filing cabinet. Patient record were retained for a period of six years. Once each scan had been completed these documents were scanned and stored electronically and in paper format in a locked cupboard.

Information to support referrals was communicated verbally to a maternity provider and given in paper format in an envelope to the patient. The service could also send encrypted electronic copies of referral paperwork directly to NHS providers. Informed consent forms were stored in paper and electronic format, these remained on file for six years.

Incidents

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

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

Good

Diagnostic imaging

Staff knew what incidents to report and how to report them. Staff told us how they would report any incidents to managers. The service had no never events.

Managers investigated incidents thoroughly. Women were involved in these investigations. When incidents occurred the learning and circumstances incidents were fed back to staff individually.

Staff received feedback from investigation of incidents internal to the service by email or verbally. Staff did not meet to discuss the feedback from incidents. Staff told us that there had not been staff meetings and communication from their experience was always on an individual basis. However the directors informed us of timely meetings as required and at least twice per year. Staff told us they felt that staff meetings would enable discussion and shared knowledge on ways the service could be improved was not discussed in a group setting.

Are Diagnostic imaging effective?

Inspected but not rated

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 protected the rights of women subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Scanning forms were developed and updated in line with *British Medical Ultrasound Society (*BMUS) policies and updates were incorporated into practice. A member of the management team was responsible for clinical policy updates. Managers reviewed policies annually or when national guidance indicated a change in practice.

There were written protocols for scanning, in addition sonographers followed an electronic form for all women that guided the scan procedure and stages. This meant that scans were standardised and did not deviate from the set format.

Women outcomes

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

The service did not participate in national clinical audits. However, sonographers participated in monthly peer review of scans and followed national guidance from BMUS when reviewing these images. We saw evidence demonstrating 5% of all scans were reviewed monthly, this was around 15 images. When improvement in scanning was identified this was commented on and fed back to staff.

Managers and staff used the results to improve women's' outcomes. Scans were reviewed and areas for improvement were discussed with the sonographer who undertook the original scan. Managers told us if areas for improvement were routinely identified, staff would follow a procedure to asses capability. The service also had a disciplinary procedure in place.

Good

Diagnostic imaging

The service supported staff to rebook women for additional scanning if scans could not be completed due to foetal positioning or gestational age. When foetal anomaly was identified, women were referred to the early pregnancy unit or maternity centre where their care was based.

The service managed referrals to early pregnancy assessment unit or maternity services themselves, this ensured they knew the scan was followed up with the women by the NHS with a diagnostic procedure. In some circumstances, such as early pregnancy, information regarding foetal anomalies or miscarriage was also communicated to the woman's GP.

Managers made sure results of all non-invasive prenatal testing were sent to women electronically and explained to the woman the importance of sharing the results with the woman's maternity care provider. Follow up of Non-invasive prenatal testing (NIPT) results were undertaken by managers at the service, these were then electronically sent to the women to liase with their NHS trust. The NIPT service offered additional access to a genetic counsellor if screening indicated a likelihood of genetic abnormality, this service was provided at no additional cost to the women.

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. The service only employed sonographers that had been educated at a postgraduate level. All sonographers employed by the service were registered with British Medical Ultrasound Society (BMUS). Managers told us staff had pre employment checks which included an enhanced criminal record check.

Sonographers communicated scan details, and if requested gender, to women during the scan. When referrals were required this step was undertaken by management or sonographers. When sonographers were unable to complete a referral, due to workload this would be picked up by managers.

Managers gave all new staff a full induction tailored to their role before they started work. Staff worked in pairs of a customer care assistant and a sonographer to run scanning sessions, but when new staff started in the administrative roles, managers ensured they were also present to support training. Sonographers new to the service were able to observe experienced staff undertaking scans until they, and managers, felt confident they were familiar with the scanning procedure and equipment. Staff completed a three month induction process, but managers told us this could be extended if managers and staff agreed more support was needed. The service has a formal process in place to review staff capability if managers felt they were not performing.

Managers supported staff to develop through yearly, constructive appraisals of their work. All staff had a yearly appraisal. These covered areas of reflection for staff and gave a chance for positive and constructive areas of improvement.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us when identified areas for improvement in their clinical knowledge, the service had supported them undertake additional training. A member of the management team was also undertaking post graduate training to work as a sonographer in the service.

Multidisciplinary working

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

Good

Diagnostic imaging

Staff worked across health care disciplines and with other agencies when required to care for women. The service made referrals to local NHS trusts, or if needed to the woman's GP. Some staff in the service also worked in substantive roles within NHS trusts. Managers followed up on referrals directly with NHS services to assure themselves the women had attended for diagnostic tests following scans that suggested foetal anomaly.

The service had developed links with the local safeguarding authorities and were familiar with the local multi agency safeguarding hub. When referrals were completed for safeguarding this was followed up by managers to ensure the information had been received.

When NIPT was undertaken, once results were received by the service these were relayed verbally or face to face to the woman. Electronic details of NIPT screening were also emailed directly to the women. Women could choose to discuss results with a genetic counsellor, this was provided by a third party that processed the tests. Women were also advised to contact their maternity care provider for further screening. The service managed the sending and tracking of NIPT samples and followed up on any delays directly with the courier. They ordered 'cold packs' in advance when NIPT was booked on or close to a weekend. This meant blood samples that may be delayed, due to postal service slowdowns at weekends, would not be compromised. Women having NIPT were advised that the period for results was based on the receipt date in the laboratory, as such when blood samples were delivered the service contacted the women to advise them.

Seven-day services

Services were available to support timely care.

The service offered appointments in the evening and on weekends to enable woman to book scans at a time that suited their lifestyle. The service was able to rebook a woman if all wellbeing checks or gender could not be obtained in the initial appointment. Women were able to book online or phone the service and appointments were available for the following day, this included weekends and bank holidays.

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 some women's consent. However for women who lacked capacity, the policy to gain consent did not follow national guidance.

Staff understood to assess whether a woman had the capacity to make decisions about their care. Staff undertook training in mental capacity either through the service or in their substantive NHS roles.

Bookings were overseen by manager and customer care assistants, due to the size of the service, women that had attended previously in the same pregnancy were picked up easily. This meant if women attended repeatedly it would be flagged. Managers told us if staff felt repeated attendance caused concerns for mental health they would then contact the woman directly to discuss any concerns, and signpost to maternity services if needed but they had not needed to do this.

Staff made sure women consented to treatment based on all the information available. Informed consent forms outlined the scan and its limitations. This included the safety of scanning and what to expect. Women were advised that all scans were not diagnostic, and any anomalies or unexpected findings needed confirmation from the woman's maternity provider.

Good

Diagnostic imaging

Staff gained consent from women for their care and treatment in line with legislation and guidance. Parental consent was required for women under the age of 18. Women provided consent for foetal health information to be shared with maternity providers or GP if scanning indicated this was needed. Staff clearly recorded consent in women's' records.

During inspection we saw informed consent forms contained a box for someone to provide consent for women who lacked capacity, it was not clear when this would be used. The service provided a policy post inspection which contained information that was not accurate and may encourage scanning services to be used inappropriately for women who cannot not self-consent. For the range of services offered by this service none would be medically indicated for women who lacked capacity.

Records

All staff had access to an electronic records system that they could all update.

Staff always had access to pre consent forms and wellbeing paperwork during the scanning process. Once each scan had been completed these documents were scanned and stored electronically and in paper format in a locked cupboard.

Nutrition and Hydration

Staff offered cooled bottled water to women when requested or to encourage foetal movement.

Are Diagnostic imaging caring?

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. Appointment length was adequate to ensure when required, sonographers could discuss foetal health concerns and the need to refer to maternity services. The service had developed a system to make administrative staff aware as soon as scanning had been completed if a referral was needed. This ensured staff could be discreet and compassionate when making referrals and that any conversation regarding the details was kept to a minimum. This also meant administrative staff were aware of the need to keep waiting areas clear of other women attending the service. Staff did this by directing women to outdoor waiting areas and taking all paperwork outside to them.

Staff followed policy to keep women's information confidential. The service booked appointments in a way that meant women could leave the service discreetly and without distress being apparent if bad news had been given. Conversations in the scanning room could not be overheard in any area of the building.

Women said staff treated them well and with kindness. Client feedback was positive and praised staff for their care and kindness. During our inspection we saw staff interacting with women in a respectful and considerate way. Staff told us how they understood the need to be compassionate and sensitive when women had scans indicated miscarriage or foetal anomaly.

Good

Diagnostic imaging

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs. Woman were able to attend with family groups of up to five people and children were able to attend scans.

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 undertook training on breaking bad news and demonstrated empathy when having difficult conversations. When scanning indicated miscarriage, maternal risk factors or foetal anomaly, the sonographer who explained the referral process and the need for further diagnostic tests. Information to support referrals was communicated verbally by the service to a maternity provider and given in paper format in a sealed envelope to the patient, the service also created an electronic record in case the woman misplaced the original document.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. The layout of the reception area meant that other guests and women were not likely to be in the vicinity of the scanning area or reception while scanning was occurring. This meant women could leave the service, when distressed without seeing other women and their families.

When women chose NIPT as part of their booking, a telephone conversation was had in advance to manage expectations and make woman aware of the limitations. Women were also given electronic information's explaining NIPT testing and the different screening packages available and fees involved.

Understanding and involvement of women and those close to them

Staff supported and involved 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. Booking for scanning packages and NIPT services could be made online or by telephone. Fees were clearly displayed on the website or verbally. The fees charged were fixed but additional images and keepsake items, such as confetti cannons and balloons could also be purchased in addition to this. Informed consent forms advised that guests and young children remain outside the scan room until initial foetal health checks had been completed.

Staff talked with women and their families in a way they could understand. When women were under the age of 18 the service ensured that information was communicated to both the woman and the person with parental responsibility.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. The service enables women and their families to provide feedback through social media and search engine review sites. In addition to this, managers also sent anonymous electronic feedback surveys to women following their appointment. Managers sent these surveys to patients individually to ensure that women who were given bad news at their appointment did not receive them, to avoid causing additional distress.

Women gave positive feedback about the service. Women said that they found staff friendly and caring. We saw feedback from women who had experienced multiple pregnancy loss but used the service for subsequent pregnancies due to the compassionate way staff had dealt with them at previous attendances.

Good

Diagnostic imaging

Are Diagnostic imaging responsive?

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 services so they met the changing needs of the local population. Women could pick the time slot that suited them. Scanning was available at weekends and in evenings. In addition to scanning the service offered NIPT through a third party and managed the sending of blood samples and communication of screening results themselves.

Facilities and premises were appropriate for the services being delivered. The service allowed full access to all areas for disabled people. There was unrestricted parking and easy access to quiet outdoor areas if needed.

Meeting people's individual needs

The service took account of some women's individual needs and preferences. They directed women to other services where necessary. However information leaflets were available only in English.

Appointment length considered ultrasound scanning time and the opportunity for the woman to ask questions if needed. Patients could also contact the service online or by phone and ask questions in advance. The service website also featured an area with frequently asked questions. Information and leaflets were not available in other languages or formats. There was also no information in an accessible format available. The service could use an online translation service, staff told us women could also attend with a guest who could translate but this is not considered best practice.

Access and flow

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

Managers monitored and took action to minimise missed appointments. Managers ensured that women who did not attend appointments were contacted. If appointment times were missed by patients, managers took steps to rebook them. When women had their appointments cancelled at the last minute managers made sure they were rearranged as soon as possible.

Staff supported women when they were referred to NHS maternity services. The processes for referral was explained to women but the service managed the process for them to avoid additional distress and clear communication regarding concerns.

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.

Good

Diagnostic imaging

Women and relatives knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in waiting areas. The service had a complaints policy that could also be provided to patients. Complaints could be made verbally or in email and the service had a policy of responding to these within three working days. We saw that the service always responded in line with its policy acknowledging receipt of a complaint and usually did this within 24 hours.

The service also allowed online reviews through social media and search engine rating sites. The service took steps to respond to all feedback, both positive and negative, to establish ways that they could improve.

We saw examples of women who had contacted the service to raise complaints and saw that these were followed up and where possible resolved to a satisfactory conclusion.

Staff understood the policy on complaints and knew how to acknowledge them. Managers investigated complaints. Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used women's feedback to improve daily practice. We saw examples of changes in the room layout following patient complaints that stated the television screen could not be seen by some women during scanning. We also heard how the service had stopped selling gender reveal crackers following complaints that these items sometimes tore and accidentally revealed foetal gender.

The service had a complaints procedure which women could follow. Managers showed us examples of complaints raised by women and how these were responded to. The service took steps to explain their complaints process to women and were quick to respond to complaints.

Are Diagnostic imaging well-led?

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. They supported staff to develop their skills.

Staff felt managers were visible and approachable. We heard examples of staff being supported to develop their skills and were told managers would always support staff development. Staff could contact managers when needed and told us that managers supported them by completing task such a safeguarding referral when the service was busy. A member of the management team was undertaking post graduate training in sonography to further support staff and the development 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, developed with relevant stakeholders.

Leaders and staff understood the vision of the service and monitored progress of customer experience through feedback. The service placed a strong emphasis on customer experience being as positive as it could be. Services and the environment were developed in line with its vision to support maternal wellbeing. There was a commitment to improving and maintaining good customer experience and leaders rewarded staff for positive customer interactions.

Good

Diagnostic imaging

There was strong consideration on how outcome of scans could be both positive and negative with equal weighting. The vision of the service was aligned with supporting women during difficult outcomes and unexpected news.

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.

The service welcomed feedback from women and their families. It made submitting reviews easier and more transparent by having a social media presence. They also actively sought out feedback from women, while considering the impact of this step on woman who had experienced poorer outcomes. The service was aware of the impact bad news could have on a woman and her family and took reasonable steps to minimise distress to the woman and her family.

Governance

Leaders operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities, however there were not regular opportunities to meet as a group and discuss and learn from the performance of the service.

Communication to staff was conducted by email but also verbally. Staff told us there was a lack of group conversation for fully sharing experiences and learning opportunities.

Staff told us that meetings would benefit their working environment and also improve wellbeing. We also heard how staff felt that the service could be improved if they could share ways of working and this would benefit women.

Management of risk, issues and performance

Leaders used systems to manage performance effectively.

They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. The service had clear policies in place for patient referral. There was peer review of imaging that highlighted areas of improvement and this was to the benefit of patients. Staff were clear about their roles and had appraisals to discuss performance and development.

Information Management

The service collected reliable data and analysed it.

Staff could find the data they needed, in easily accessible formats. The information systems were integrated and secure. Managers had developed electronic records in order to reduce paper and make completion or records simpler. Safeguarding notifications were consistently submitted to external organisations in line with local policy as required.

Engagement

Managers and staff actively and openly engaged with women.

The service website offered multiple routes for women to contact the service to get information. There was also a frequently asked question section on the website.

Good

Diagnostic imaging

The service regularly corresponded with NHS providers to create and follow an NHS referral process. The service felt regular correspondence has helped to ensure appropriate referrals and acts as a way to audit referrals and share learnings.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Leaders supported staff development and encouraged this at appraisals.