Somerset Early Scans Limited

Taunton Road Medical Centre

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	Outstanding ☆
Are services safe?	Outstanding ☆
Are services effective?	Inspected but not rated ●
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Overall summary

At our previous inspection of the service on 25 July 2019 we rated it Good overall.

At this inspection, we rated it as outstanding because:

- People were protected by a strong safety system with a focus on openness, transparency, and learning when things go wrong. The service had enough highly qualified staff to care for women and keep them safe. The registered manager was a GP with previous experience managing an NHS recurrent miscarriage service. They brought this breadth of experience to leadership of the service. Staff had training in key skills, understood how to protect women from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided excellent care and treatment. Managers made sure staff were competent. Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. The service had been nominated for a range of awards. Recently, it had won the 'Ultrasound Clinic of the Year Award 2022' and were runners up in the Somerset Business Awards 2021 for 'Service Excellence'.
- People were truly respected and valued as individuals and were partners in their care, practically and emotionally by an exceptional service. Staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. There were high levels of emotional support available to women and their companions. We saw extensive evidence of positive feedback from women who had used the service. This included from women who had received difficult news, and those who had experienced pregnancy loss.
- Services were tailored to meet the needs of individual people and were delivered in a way that ensured flexibility and choice. 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 told us they could access the service when they needed it and did not have to wait too long for their results. Women were supported by chaperones, to ensure women felt comfortable and received optimum emotional support. All staff received communication training to offer emotional support.
- The leadership, governance and culture were used to drive and improve high-quality person-centred care. The registered manager recognised the importance of and demonstrated commitment to best practice performance. Leaders ran services well using reliable information systems and supported staff to develop their skills. The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in this field would flourish. There were effective structures, processes and systems of accountability to support the delivery of the good quality and sustainable services.
- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services and all staff were committed to improving services continually. Leaders strived to deliver and motivated staff to succeed. Personal and professional staff development was positively encouraged and there was a deeply embedded system of leadership development and succession planning.
- At the last inspection evidence of satisfactory checks were not always obtained before staff started work. At this inspection, we found these had both been addressed.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for adults	Outstanding ☆	At our previous inspection of the service on 25 July 2019 we rated it Good overall. At this inspection, we rated it as outstanding because: • People were protected by a strong safety system with a focus on openness, transparency, and learning when things go wrong. The service had enough highly qualified staff to care for women and keep them safe. The registered manager was a GP with an extended role managing an NHS recurrent miscarriage service and the consultant was an expert in early pregnancy. They brought this breadth of experience to leadership of the service. Staff had training in key skills, understood how to protect women from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service. • Staff provided excellent care and treatment. Managers made sure staff were competent. Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. The service had been nominated for a range of awards. Recently, it had won the 'Ultrasound Clinic of the Year Award 2022' and were runners up in the Somerset Business Awards 2021 for 'Service Excellence'. • People were truly respected and valued as individuals and were partners in their care, practically and emotionally by an exceptional service. Staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. There were high levels of emotional support available to women and their companions. We saw extensive evidence of positive

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feedback from women who had used the service. This included from women who had received difficult news, and those who had experienced pregnancy loss.

- Services were tailored to meet the needs of individual people and were delivered in a way that ensured flexibility and choice. 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 told us they could access the service when they needed it and did not have to wait too long for their results. Women were supported by chaperones, to ensure women felt comfortable and received optimum emotional support. All staff received communication training to offer emotional support.
- The leadership, governance and culture were used to drive and improve high-quality person-centred care. The registered manager recognised the importance of and demonstrated commitment to best practice performance. Leaders ran services well using reliable information systems and supported staff to develop their skills. The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in this field would flourish. There were effective structures, processes and systems of accountability to support the delivery of the good quality and sustainable services.
- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services and all staff were committed to improving services continually. Leaders strived to deliver and motivated staff to succeed. Personal and professional staff development was positively encouraged and there was a deeply embedded system of leadership development and succession planning.

Summary of findings

- At the last inspection evidence of satisfactory checks were not always obtained before staff started work. At this inspection, we found these had both been addressed.

Summary of findings

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Summary of this inspection

Background to Taunton Road Medical Centre

Somerset Early Scans at Taunton Road Medical Centre is operated by Somerset Early Scans Ltd. The service is based on the first floor in the GP surgery of the same name. This service provides diagnostic obstetric ultrasound scanning for pregnant women from 16 years of age and scanning from six weeks of pregnancy to full term. It also provides non-invasive pre-natal tests and women's health scans. The service is provided to self-funding women across Somerset.

We inspected this service using our comprehensive inspection methodology. We carried out a short-notice announced inspection on 7 April 2022. After the inspection, we telephoned women who had used the service to gather their views. The service opened in August 2014 and re-registered in 2016 following a change in its legal identity.

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.

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 service provided the single speciality core service: Diagnostic and screening procedures

How we carried out this inspection

We carried out a comprehensive inspection of the service under our regulatory duties. The inspection team comprised of a lead CQC inspector and overseen by a CQC inspection manager. We gave the service short notice of the inspection because we needed to be sure it would be in operation at the time we planned to visit.

We undertook this inspection as part of a random selection of services rated Good and Outstanding to test the reliability of our new monitoring approach.

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

Outstanding practice

Clinical staff employed at the service had published articles and presented materials at both national and international conferences. The service had won national awards. Staff had received national recognition for their work.

The registered manager designed a flow chart to support sonographers identifying ectopic pregnancies and pregnancies in unknown locations. Staff were overwhelmingly positive about this innovative tool and the difference it made to them.

Feedback from women was overwhelmingly positive. Women who received bad news also provided positive feedback and shared their experiences to help other women. For example, staff visited women in hospital to provide emotional support.

Summary of this inspection

The provider's website had monthly blogs which provided women and their family/friends with an excellent source of information, covering topics for women about their pregnancy, health needs or fertility needs.

The service provided outstanding support for charities supporting projects to improve the health of women and children.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	☆ Outstanding	Inspected but not rated	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Overall	☆ Outstanding	Inspected but not rated	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding

Outstanding ☆

Community health services for adults

Safe	Outstanding ☆
Effective	Inspected but not rated ●
Caring	Outstanding ☆
Responsive	Outstanding ☆
Well-led	Outstanding ☆

Are Community health services for adults safe?

Outstanding ☆

Our rating of safe improved. We rated it as outstanding.

Mandatory training

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

Staff received and kept up-to-date with their mandatory training, both with this service and training required by their substantive posts in the NHS. The mandatory training was comprehensive and met the needs of women and staff. The registered manager ensured all staff completed a range of mandatory training which included fire safety, infection control, safeguarding, health and safety, Mental Capacity Act, equality and diversity and information governance.

Staff also completed role specific mandatory training. For example, staff completing forms with women which required confidential personal information were required to complete 'recording information and General Data Protection Regulations (GDPR)'. At the time of our inspection, all staff had completed their mandatory training except for the registered manager, who had basic life support training outstanding. This was because the training provided as part of their role as a GP had been postponed due to pressures on the GP practice. This training had been rescheduled.

The registered manager and nurse practitioners had attended fertility treatment training provided by an external company in preparation for opening a fertility clinic. Staff also attended an annual early pregnancy conference. This ensured they were always up to date with most recent advances. Staff also refreshed training for breaking bad news during these conferences.

The registered manager monitored compliance with mandatory training and alerted staff when they needed to update their training. Staff confirmed they were given enough time to do training.

The registered manager ensured staff could access online training appropriate for the service. Staff told us they were able to request additional training, and this would be provided for them.

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. The service had clear safeguarding processes and procedures. All staff were trained to at least safeguarding level two for both vulnerable adults and children. For example, healthcare assistants completed safeguarding level two training and the registered manager and consultant obstetrician completed safeguarding level three training. The registered manager was the safeguarding lead.

Staff knew how to make a safeguarding referral and who to inform if they had concerns, although they had not made any safeguarding referrals in the past year. There were signs in the toilets informing women to raise any concerns about domestic violence with staff. Staff had access to an up-to-date safeguarding policy. Staff we spoke with were able to clearly articulate signs of different types of abuse and the types of concerns they would report or escalate to the registered manager.

A separate female genital mutilation (FGM) policy provided staff with clear guidance on how to identify and report FGM. Safeguarding training also covered FGM.

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.

Everyone arriving at the clinic was asked about their current health status. Different levels of screening were used based on risk. All visitors were asked to sanitise their hands and wear masks.

Clinical areas were visibly clean and had suitable furnishings which were visibly clean and well-maintained. The clinic room and toilets were all visibly clean. To reduce infection risk, women were asked to wait in their cars in the car park and staff would collect them and escort them to the scan room.

The registered manager had updated the COVID-19 policy to provide guidance for staff to help reduce the spread of infection. Staff followed the scan room safety and hygiene required by their IPC and COVID-19 policies.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff completed a daily cleaning log and undertook cleanliness visibility checks of toilet areas throughout their shifts. The registered manager had introduced more detailed cleaning logs in response to COVID-19 which prompted staff to clean every surface in the room used. For example, the couch in the treatment room used by women was covered with a disposable cloth which was changed between patients. Staff completed a complete wipe-down of the room and equipment used after each appointment. This included anything that may have been touched such as the couch, light switches and door handles.

Staff followed infection control principles including the use of personal protective equipment. The service had appropriate handwashing facilities and sanitising hand gel was available. Staff told us they had their arms bare below their elbows during clinics and washed their hands before and after each scan. We observed this in the member of staff in the clinical area and photographs of the staff in uniforms showed all staff below the elbow. Personal protective equipment such as latex-free gloves and antiseptic wipes were readily available for staff to use at the service.

In the twelve months before the inspection there had been no incidences of healthcare acquired infections at the location.

Sonographers followed the manufacturers and infection prevention and control guidance for routine disinfection of equipment. Sonographers wore gloves when carrying out scans in line with infection prevention and control guidance.

The service offered non-invasive pre-natal testing (NIPT) services and had a contract with an accredited laboratory. Non-invasive pre-natal testing means the baby's DNA circulating in the mother's blood can be checked for certain chromosomes. An abnormal number of these chromosomes could indicate the presence of certain inherited conditions, such as Down's Syndrome, Edward's Syndrome and Patau's Syndrome. Down's Syndrome is a condition where a person has an extra chromosome. Babies with Edwards' syndrome have an extra copy of chromosome 18 in all or some cells. Babies with Patau's syndrome have an extra copy of chromosome 13 in all or some cells. The tests can be done as early as ten weeks into the pregnancy. The registered manager monitored the time it took to receive results.

The service had a non-invasive pre-natal testing procedure outlining the steps to take when obtaining blood samples. The guidance cross-referred to the service's infection prevention and control policy, outlining hand hygiene steps and the safe disposal of sharps and clinical waste to prevent and control the spread of infection.

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.

The service had suitable facilities and enough suitable equipment to meet the needs of women. The clinic's environment was fit for the purpose of service provided. There was one scan room with a modern couch which could be adjusted. The scan room also had a hand-washing sink and storage cupboards for disposable items.

The service had access to a resuscitation trolley from the GP surgery. There was a first aid box available which was within expiration date. Staff were up-to-date with adult and children first aid training. Staff told us in case of an emergency they would call 999.

In line with the safety policy, staff completed regular checks of stock, first aid kit and equipment. Staff carried out daily safety checks of specialist equipment. The scan equipment was serviced annually and maintained by the company who installed it. The equipment was new in March 2019 and was covered by a one-year warranty. The machine was serviced annually with the last service completed in January 2022. The registered manager explained they would call an engineer if the machine needed any attention. The electrical equipment had been safety tested in February 2022.

Staff disposed of clinical waste safely. Staff carried out waste streaming in line with Department of Health and Social Care Health Technical Memorandum 07-01, which reflected national best practice. Staff wore correct PPE while dealing with clinical waste and followed a safe process. Clinical waste was safely stored in a secure, locked area at the back of the premises, with locked bins. The area could only be accessed with a key. The sharps bins for needles used for taking bloods were stored safely and emptied quarterly or before if they became full.

Disposable equipment was labelled with dates when it was opened and disposed of when the expiry date was reached.

The service had safe facilities and equipment for taking blood samples. The non-invasive prenatal test procedure provided clear instructions on the labelling, packaging and method of postage. In addition, the package was sent via

recorded delivery to enable tracking. Non-invasive prenatal testing kits came in individual packs with one for each woman. The kit contained individual needles, a tourniquet (used to obtain blood samples through applying pressure on the arm) and vials for blood samples. Most staff were already qualified to take bloods. However, one sonographer completed phlebotomy training so they could also take bloods.

Assessing and responding to patient risk

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

The registered manager took a proactive approach to anticipating and managing risks to women. They described the decision they took not to provide routine scans during COVID-19 lockdown. They sought guidance from the Royal College of Obstetricians and Gynaecologists, Association of Early Pregnancy Units, the British Medical Ultrasound Society and the Southwest health protection team at Public Health England before taking the decision to close to all but urgent scans.

Innovation was used to achieve sustained improvements in safety and continual reductions in harm. The registered manager designed a flow chart to support sonographers identifying ectopic pregnancies and pregnancies in unknown locations. Staff were overwhelmingly positive about this innovative tool and the difference it made to them.

Staff knew about and dealt with any specific risk issues. The service provided clear guidance for sonographers to follow when they identified unexpected results during a scan. This was referenced in the provider's policy, which stated every woman would have a diagnostic wellbeing check. Should any anomalies be found, women told us staff informed them in a caring, honest and professional manner. The woman was given a detailed medical report clearly explaining the scan findings. Staff followed the referral pathway agreed with the local NHS trust, Foetal Medicine Unit or Early Pregnancy Unit. All scans were diagnostic. The range of scans included early scans, second and third trimester scans, women's health scans and fertility scans.

Staff gave examples of redirecting women who were experiencing pain or bleeding to their local NHS clinical team. Sonographers made rapid referrals when they found concerns about a woman's health and documented their phone calls with NHS services to maintain an audit trail of referrals.

Staff shared key information to keep patients safe when handing over their care to others. The registered manager told us they had referred 90 women to NHS services in the past year because of potential concerns found. Dedicated referral forms were available to document any referrals made. These included a description of the scan findings, the reason for referral, who the receiving healthcare professional was and what action they were going to take.

Staff responded promptly to any immediate risks to women's health and in any emergency. Staff would phone 999 if they suspected anything which required urgent action.

Staffing

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

Outstanding ☆

Community health services for adults

Women were safely cared for by sufficient numbers of skilled and experienced staff. The service employed ten members of staff altogether. These included six members of staff qualified to scan; two doctors, two nurse practitioners and two advanced practitioner sonographers. One nurse practitioner was a qualified midwife with a post graduate qualification in ultrasound and was also a trainer in ultrasound and teaching students of radiography how to scan. Another nurse practitioner had a post graduate qualification in ultrasound and specialised in early pregnancy and fertility. The two advanced practitioner sonographers both held postgraduate qualifications in medical ultrasound and were registered with both the Health and Care Professions Council and were members of the Society of Radiographers. Three clinic assistants supported the sonographers.

The registered manager planned staffing levels to meet demand on the service, measured by the number of bookings made in advance.

The registered manager gave all new staff a full induction tailored to their role and experience before they started work. The induction programme included providing information about staff roles and responsibilities, and mandatory and role-specific training. New staff also completed a six-month probation period.

The service had low vacancy, turnover, and sickness rates and staff described the team as consistent and stable. The service did not use locums or agency staff.

Records

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

Women's notes were comprehensive and all staff could access them easily. Information was collected from women during their appointment and recorded on the scan report and sufficient information was obtained from women before their scans. For example, this included the number of weeks pregnant and the number of previous pregnancies. Women were also asked to declare medical conditions that might affect their scan.

Staff ensured women's confidential personal information was secured and not accessible to anyone without authorisation to see it. For example, women's registration forms were kept at reception in a covered clip board before they were called in to the scanning room.

Records were stored securely. Most records were kept electronically and computers were password protected. When a woman was referred on to an NHS hospital, a copy of the referral was printed and given to the woman to take to the hospital. Reports were put into a folder for the woman to take so no paperwork was visible.

After initial consultations, the service held contact details for women awaiting test results from non-invasive prenatal testing. The IT systems they used could be shared with healthcare providers.

The service had an up-to-date information governance policy and a data retention policy. The registered manager was the information governance lead for the service. The service was registered with the Information Commissioner's Office.

Incident reporting, learning and improvement

Outstanding ☆

Community health services for adults

The service managed safety incidents well. Staff recognised and knew how to report incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women honest information and suitable support.

All staff are encouraged to participate in learning to improve safety as much as possible. Learning was based on a thorough analysis and investigation of things that go wrong. Staff knew what incidents to report and how to report them. The service had an up-to-date incident reporting policy, which detailed all staff responsibilities to report, manage and monitor incidents. The service used an electronic system to report incidents and an incident log was available in the clinic. If an incident was to occur, the registered manager was responsible for conducting investigations into all incidents at the location.

The registered manager had a sustained track record of safety supported by accurate performance information. There had been five clinical incidents at the time of our inspection. These were incidents such as staff identifying an ectopic pregnancy or pregnancy in an unknown location. Each incident was discussed at quarterly meetings. The registered manager had taken an effective response to these incidents and had designed a flowchart to take sonographers through the steps they needed to cover for certain events. Staff provided positive feedback about this action to support their work. The quality assurance feedback monitoring form had specific areas to document actions taken, by whom and mitigating steps taken to ensure avoid occurrence of potential incidents.

Since the service opened in August 2014 to this inspection, there were no 'never events', or serious incidents at the location.

Staff understood the duty of candour. In the past year, there were no incidents requiring duty of candour notifications. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager could explain the process they would undertake if they needed to implement the duty of candour because of an incident, which was in line with the regulatory requirements.

Are Community health services for adults effective?

Inspected but not rated

We do not currently rate effective.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver effective care according to best practice and national guidance. Staff were aware of how to access policies, which were stored electronically and a folder in the clinic.

Outstanding ☆

Community health services for adults

Local policies and protocols were in line with current legislation and national evidence-based guidance from professional organisations, such as the National Institute for Health and Care Excellence and the British Medical Ultrasound Society. Staff were made aware of updates to policies during quarterly team meetings. All policies and protocols had a next renewal date which ensured they were reviewed by the service in a timely manner.

Sonographers used minimum frequency levels for a minimum amount of time to achieve the best result. To ensure this, the service followed the 'As Low as Reasonably Achievable' principles. This was in line with national guidance (Society and College of Radiographers and British Medical Ultrasound Society, Guidelines for Professional Ultrasound Practice (December 2018)). Machines were pre-set to the lowest frequency and this was checked during scans.

All scans started with a wellbeing check. The sonographer looked at the baby's movements, heartbeat, position, and placental position. The sonographer also looked at the presentation of the baby, head and abdominal circumference measurements. Other measurements, such as femur length measurements and estimated foetal weight were done on growth and presentation scans.

The service had an effective audit programme that provided assurance about quality and safety. The registered manager carried out audits where they monitored women's experience, cleanliness of the premises and equipment, health and safety, ultrasound scan reports, policies and procedures. The registered manager also completed annual sonographer competency assessments.

Sonographers audited each other's scans and scan documentation. They reviewed the report and image quality and checked when a referral was needed that it had been made to the appropriate service. The registered manager had oversight of this.

Thirty scans from the period 1 July 2021 to 30 September 2021 were reviewed to audit the quality of the scan and the report. Whether the ovaries were visible or not were commented on in 100% of the reports. In only one review there was no image where the report mentioned the ovary was not identified. The audit therefore recorded the standard had been achieved in 96.7% of cases. These reviews were planned to continue. Audits were shared with staff and used as opportunities to identify learning and drive the culture of high quality, sustainable care.

Audits showed 100% achievement of standards. For example, the consent for information sharing audit and the room cleaning log was completed in 100% of clinics. This included extra cleaning between every client due to COVID-19 precautions. The probe cleaning log was also completed in 100% of uses and the hand washing audit was 100%.

The service used technology and equipment to enhance the delivery of effective care and treatment to women. The service utilised up-to-date scanning equipment to provide high-quality ultrasound images. It had one wall-mounted screen situated in the scan room which enabled women and their guests to view their baby more easily. Women were able to bring one adult and one child to accompany them. Numbers of guests were restricted due to the size of the room.

Women were able to access their scan photos and download them onto their phone/laptop, using a link sent to them.

The service was inclusive to all pregnant women and supported all women regardless of their age, disability, pregnancy and maternity status, race, religion or belief, and sexual orientation to make their own care and treatment decisions.

Nutrition and hydration

Staff took into account women's individual needs where fluids were necessary for the procedure.

Due to the nature of the service, food and drink was not routinely offered to women. However, bottles of drinking water were available. To improve the quality of the ultrasound image, women were asked to drink extra fluids on the lead up to their appointment. Women who were having a gender scan were encouraged to attend their appointment with a full bladder. This information was given to women when they contacted the clinic to book their appointment. It was also included in the 'frequently asked questions' on the service's website. Staff told us they would offer a small bag of sweets if the baby was not in the right position for a 4D scan as sugar was known to stimulate movement.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain during scans.

Staff checked women were comfortable during their scan and halted scans if women experienced any discomfort.

Patient outcomes

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

The registered manager collected data on an on-going basis to monitor effectiveness of the service. This enabled the registered manager to understand what audits were needed to give valid data and identify trends and areas for improvement. Audits identified the standards expected and whether these standards had been met. For example, early pregnancy scans were audited to check the area surrounding the ovaries had been scanned and commented on, though sometimes it was difficult to see the ovaries. Both the report and images were reviewed, and the audit standard was achieved in 96.7% of cases.

Sonographers were part of a peer review process to ensure the accuracy and quality of ultrasound scan images, videos, and reports.

The registered manager ensured there were clear criteria for carrying out scans and repeat scans. Rescans were done in the most appropriate timescales. This was to ensure women were not persuaded to have multiple scans which would not have given them any more information than they already had.

Staff made women aware they could get non-invasive pre-natal testing blood tests through the NHS if they were high risk. Women were able to discuss their options and whether to wait for this.

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. Staff accessed their training through the service's electronic training portal. Training records confirmed staff had completed role-specific training.

The registered manager conducted an initial competency assessment of sonographers when they first joined the service. The registered manager also completed a competency assessment during appraisal reviews which included checking sonographer's registration, indemnity insurance and revalidation status.

Managers made sure staff received any specialist training for their role. For example, staff who took bloods for non-invasive pre-natal testing were either qualified doctors or had done phlebotomy (blood collection) training. Phlebotomists were trained to be able to explain and discuss the benefits and limitations of non-invasive pre-natal testing with women.

Managers identified any training needs their staff had. Staff had the opportunity to discuss training needs with the registered manager and were supported to develop their skills and knowledge.

The registered manager would manage any performance issues of sonographers. The IT system meant other sonographers could provide guidance to sonographers on or off site and identify specific types of scans during which to target support.

At the last inspection evidence of Disclosure and Barring Service checks (DBS) was not always obtained before staff started work. References for new staff did not always contain information about their conduct from senior staff from their last place of work. At this inspection, we found these had both been addressed.

Managers had a thorough appraisal process to support staff to develop through annual constructive appraisals of their work. Staff had their first appraisal after six months with the service and then annually. All staff were up to date with appraisals. Appraisals included 360-degree feedback from colleagues and women who had used the service.

Staff maintained their registrations with all the relevant bodies, namely the General Medical Council, Nursing and Midwifery Council, Society of Radiographers and followed their codes of conduct.

Multidisciplinary working

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

The team worked well together and communicated effectively for the benefit of the women and their families.

Staff worked across healthcare disciplines and with other agencies when required to care for women. The service had links with the local NHS trusts to ensure they had effective referral pathways for women when needed. The service had established pathways to refer women to a local NHS trust if any abnormalities or concerns were identified. Sonographers were also able to access support from other sonographers. For example, they could contact another sonographer to ask them to look at scans for a second opinion if required.

The registered manager was able to track non-invasive pre-natal testing samples from when they were received in the laboratory, when they were analysed and when the results were sent out. Women could share this information with their midwife if they chose. Staff would help women share the information if they were high risk.

Seven-day services

The service was not commissioned to offer emergency tests or treatment, although staff reminded women about calling the emergency services if necessary and gave women contact details of other NHS services available to them. However, the clinic was open Monday, Tuesday, Thursday and Friday at their Bridgewater location, and Wednesday, Thursday, Saturday and Sunday at their Elm Hayes, Paulton location. This offered flexible service provision for women and their companions to attend around work and family commitments.

If women needed an urgent scan a sonographer would stay to do this. Clinics were open between four and seven hours each day.

Booking for appointments was available seven days a week, 24 hours a day using the provider's online booking system available to their website.

Health promotion

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

The service had relevant information in patient areas promoting healthy lifestyles, for example, maintaining their health in pregnancy and general health and support. The service's website had an area for staff to record a monthly blog, where they provided excellent health and wellbeing-in-pregnancy advice. This included keeping healthy during pregnancy, foods to avoid, things to ask your midwife and when to seek medical advice. The service also had a social media page where similar information was shared.

Women were advised to contact their maternity unit immediately if they thought their baby's movements had changed. This was in line with national recommendations (NHS England, Saving Babies' Lives: A care bundle for reducing stillbirth (February 2016)).

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff completed training in relation to consent and the Mental Capacity Act 2005, as part of their induction and mandatory training programme. There was a Mental Capacity Act policy for staff to follow which clearly outlined the service's expectations and processes. Staff understood the relevant consent and decision-making requirements of legislation and guidance. The service followed the provider's policy relating to individuals who suffered from any condition covered under the Mental Capacity Act. This detailed how staff should support women and ensure they acted in their best interests.

Staff gained consent from women for their care and treatment in line with legislation and guidance. For example, the consent policy stated if staff were treating a minor, their capability to consent should be assessed regarding Fraser guidelines. This involved encouraging the patient to inform their parents if possible. It was recognised how a scan could be given without parental consent if the individual had the capacity to consent and the situation met the guidelines.

Before their scan, all women received written information to read. This included information about ultrasound scanning and safety information. There was also pre-NIPT (non-invasive pre-natal test) consent form which included terms and conditions, such as test limitations, referral consent and use of data.

A copy of the scan results was shared with the woman to share with her maternity provider if she chose to. If any anomalies had been identified, the woman was asked for her consent and the service also shared the information with the woman's maternity provider.

Staff clearly recorded consent in women's records. Sonographers were responsible for obtaining the informed consent of women and completing ultrasound (paper) reports during the woman's appointment, with the support of the scan assistant. A copy was provided to the woman to take away.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act 1983, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff received and kept up to date with mandatory training on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were aware of the provider's policies for Mental Health. They understood how and when to assess whether a woman had the capacity to make decisions about their care.

The registered manager audited the consent process and made changes as a result. The forms for women booking non-invasive pre-natal tests had been changed to explain everything in an easy to understand format. As a result, forms were always 100% completed as a result of these changes. The phlebotomist ensured women understood the procedure for non-invasive pre-natal tests and what the results could mean before they asked for the woman's consent. Consent was obtained in line with current legislation and guidance. Where anomalies were found, the results were documented, and the phlebotomist sought the woman's consent to share the information with their maternity provider.

Are Community health services for adults caring?

Outstanding ☆

Our rating of caring improved. We rated it as outstanding.

Compassionate care

Women were truly respected and valued as individuals and were empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service. Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Women were truly respected and valued as individuals and were empowered as partners in their care, practically and emotionally. Women told us staff were very attentive and would spend as much time as they needed offering them assistance, comfort, support and reassurance.

Staff were trained in communication skills and compassionate behaviours and excelled at giving people information and explanations, and sensitively managed difficult and challenging conversations. Women who had received bad news couldn't praise the service highly enough. Women described the exceptional quality of the service by commenting, "Our scan revealed very sad news, but the sonographer told us so sensitively and kindly and gave us plenty of time to take it all in. She and the practice manager both followed things up, way beyond their responsibility, liaising with other doctors, midwives and hospitals on our behalf, arranging additional appointments and checking with us every step of the way. They were exceptionally professional and so kind. Just what you need when news is not good. They could not

have been kinder or done more" and "The sonographer was so knowledgeable, reassuring and caring which made this horrendous news that little bit easier on us. The sonographer came to see me in hospital which again, seeing a face I knew from the scan really reassured me and she really went above and beyond for me. I wanted to reassure people if they don't receive the news they hope for, you are still in excellent hands."

Feedback from one member of staff included, "The compassion that comes through when giving bad news pulls on my heart strings and it goes to show the years of experience that each clinician has and how much they love their jobs."

Women told us staff consistently and emphatically treated them well and with kindness. Staff were very warm, kind and welcoming whey they interacted with women and their companions. Staff took time to interact with women and those close to them in a respectful and considerate way. A chaperone was always present during transvaginal scans.

Feedback from women included, "I went for a women's health scan. From the moment of booking to arriving, being taken to the room by the sonographer's wonderful and kind assistant to the very procedure the experience was amazing. I felt so comfortable and relaxed. I was very anxious, but I was constantly reassured and supported."

Women we spoke with were delighted with the service they received. Women told us they felt the service they received was 'excellent' and praised the staff highly. They told us staff were very friendly and kind and this made them feel very comfortable.

Women and their companions were also able to leave feedback on open social media platforms, which the registered manager frequently monitored. We reviewed a selection of reviews (from the hundreds available) and found the service was very highly rated (five stars), and feedback was overwhelmingly positive. For example, responses included statements such as, "Excellent and professional service. Very caring and helpful."

Staff were discreet and responsive when caring for women. Staff had a privacy screen to ensure the privacy and dignity of women, and women were covered throughout. The scan room door was also lockable. Staff took time to interact with women and those close to them in a respectful and considerate way. Staff were very passionate about their roles and were committed to providing personalised care.

Staff followed policy to keep women's care and treatment confidential.

Emotional support

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

Staff gave women and those close to them help, emotional support and advice when they needed it. Women could provide information at the time of booking an appointment so staff knew if there was a concern. Women who received bad news could wait in the scan room until they felt able to leave.

Staff were mindful early scans held a higher risk of complications being identified. The sonographer gave women the option of starting the scan without the screen in the room being turned on, especially if there was a child present. If any anomalies were identified the sonographer could make their diagnosis and share the information in an informed, compassionate manner. Women told us staff were calm and reassuring throughout the scan. The sonographer provided reassurance about the scan images and clearly explained what they observed. Women were told they could stop the scan at any time.

Community health services for adults

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff supported women who received upsetting news. The sonographer delivered initial feedback to women. Sonographers were able to alert other staff in a discreet way so they could give women more time and emotional support. For example, staff used discretion in the event of a scan revealing an anomaly or the lack of a heartbeat.

Staff understood the emotional and social impact that a woman's care, treatment or condition had on their wellbeing and on those close to them. The service signposted women to an external bereavement counselling charity if they required additional bereavement support. The service had access to written patient information to give to women who had received difficult news. Where women gave their consent, staff would also arrange appropriate follow-up care by contacting their midwife.

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs. For example, the service were able to supply people who did not speak English as their first language with leaflets printed in their own languages.

After initial consultations, the service held contact details for women requiring test results from non-invasive prenatal testing to enable feedback of blood test results though arrangement of a telephone call, e-mail or face to face consultation, depending on their preference. (E-mail only if the results were low chance and specifically requested by the client). Women were signposted to other services which could offer support and counselling where necessary.

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 procedures. Staff communicated with women and those accompanying them in a way they could understand. Staff adapted the language and terminology they used when performing the scan. They took the time to explain the procedure to ensure women understood. Women were able to bring two guests with them. They were made welcome in the scan room and there was one screen positioned in the scan room to ensure everyone could see the scan images. The registered manager told us during the COVID-19 pandemic they had restricted women to one visitor accompanying each woman, although these restrictions had been lifted at the time of our inspection.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. Women and their partners felt fully involved in their care and had been given the opportunity to ask questions throughout their appointment. Staff took time explaining procedures to women before and during ultrasound scans and left adequate time for women and their companions to ask questions.

Staff supported patients to make informed decisions about their care. Staff made sure women were told about the different scans available and the costs associated with them. Staff provided women with various leaflets signposting them to other care providers and reminded women they should attend their NHS appointments.

Women having non-invasive pre-natal tests had the type of tests being undertaken explained to them, including what the results would mean. Women who received bad news were signposted to other services for support and counselling.

Are Community health services for adults responsive?

Outstanding ☆

Community health services for adults

Outstanding ☆

Our rating of responsive improved. We rated it as outstanding.

Service delivery to meet the needs of local people

Women's individual needs and preferences were central to the delivery of tailored services and were delivered in a way to ensure flexibility and choice. The service also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population. The service was available between four and seven hours each day they were open. People could access services and appointments in a way and at a time that suited them. Women told us they had not had to wait to book an appointment. The service was flexible with the last appointment dependant on the number of bookings.

During COVID-19, the registered manager had taken the decision to discontinue non-urgent scans to reduce women's exposure to clinical settings and reduce the risks of spreading COVID-19. The service offered non-invasive pre-natal testing services and had a contract with an accredited laboratory. Urgent scans, such as when women were bleeding and non-invasive pre-natal tests were continued. At the time of our inspection, all scans were available.

Information about services offered at the location were available online. The service offered a range of ultrasound scans for pregnant women such as wellbeing, viability, growth, presentation, gender and 4D scans. Staff gave women relevant information about their ultrasound scan when they booked their appointment. This included whether they needed a full bladder and when was the best gestation for their scan. Ultrasound scan prices were shown on the service's website, and we observed staff clearly explaining costs and payment options to women during their appointments.

Facilities and premises were appropriate for the services being delivered. The scan room was large with enough seating and additional standing room for two guests and children of all ages were welcome to attend. The scanning room had one wall-mounted screen which projected the scan images from the ultrasound machine. This enabled women and their families to view their baby scan more easily and from anywhere in the room. This was in line with recommendations (Royal College of Radiologists, Standards for the provision of an ultrasound service (December 2014). The building had access and a lift suitable for people in wheelchairs.

Women were sent a text to remind them of their appointment and of COVID-19 requirements. The registered manager told us this helped to reduce the number of women who did not attend. The service monitored rates of patient non-attendance. The practice manager told us they were sensitive to the reasons why a woman may not have attended. If a woman suffered a miscarriage before their appointment, staff would refund the deposit payment immediately. Women were able to postpone their appointments if they phoned in advance of the appointment.

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They directed women to other services where necessary.

Community health services for adults

There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met these needs, which was accessible and promoted equality. This included people with protected characteristics under the Equality Act, and people who were in vulnerable circumstances or who had complex needs. The registered manager explained they had provided services for many same sex couples, women using donors, and the local area was a multi-cultural area. The service could provide a translation service for written documents and a telephone interpreter should these be needed. The service also used an online 'read aloud' function. The service could provide easy to read and large print information leaflets for women with vision impairment.

Women were able to access a range of scans. These included early pregnancy scans between six and 12 weeks of pregnancy and gender scans between 16 and 24 weeks. Second trimester scans included some anatomy and growth checks and could include gender identification. Reassurance scans to look for the baby's heartbeat and movements were also available in the second trimester. From 24 weeks, growth scans and 4D were available. From 36 weeks, presentation scans were available. Women's health scans involved a pelvic ultrasound scan, to look for ovarian cysts, fibroids and polyps or thickening of the womb lining.

All staff ensured women did not stay longer than they needed to. During the pandemic, women were asked to wait in their cars and staff would collect them. At the time of our inspection, women were able to wait inside. Staff were able to print photos out for people to take with them.

All members of staff were trained as chaperones. Women booked their appointments online and feedback about the booking process included, "The whole process from booking to attending was seamless."

The service had systems to help care for women in need of additional support or specialist intervention. Women were given information about what was included in the various scans available, information included what each scan entailed. Women with a history of ectopic or failed pregnancy had a range of scans they could access.

Gender confirmation from 16 weeks and growth scans were also available. Women who mostly wanted a scan for souvenir purposes had a wellbeing scan as well and could view their baby in 4D as well as 2D. NHS pregnancy scans show a two-dimensional image. A 4D scan enables women to see their baby moving as a 3D image.

Women who wanted to find out the gender of their baby outside of their appointment, such as at a gender reveal party with their family and friends, were given a sealed envelope with a printed picture telling them whether they were expecting a boy or a girl. The sonographer could turn the screen off while looking for the baby's gender.

Access and flow

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

All women wanting baby scans self-referred to the service. Women wanting gynaecology scans sometime self-referred themselves or were referred from their GP. Women could book their scan appointments by phone, email or through the service's website. People could purchase a voucher so women could book a scan when they liked. Women were given their results promptly, they were given a written report and copies of the images following their scan, to take home with them. Women could access the images electronically through the service's medical notes software portal. Women could also purchase USB drives containing the information and images in electronic format. The registered manager audited response times for women having non-invasive pre-natal tests and results showed they received their results in the time frames agreed.

Outstanding ☆

Community health services for adults

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.

Women, relatives and carers knew how to complain or raise concerns. The service had an up-to-date complaints policy, which outlined procedures for accepting, investigating, recording and responding to local, informal, and formal complaints about the service. The policy confirmed that all complaints should be acknowledged within three working days and resolved within 20 working days.

The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them. The registered manager investigated any complaint received but also attempted to deal with concerns at the time to resolve women's concerns. Staff asked women if they were happy with the service they received at the end of their appointments to identify any potential dissatisfaction while the woman was still on-site.

The registered manager investigated complaints and identified themes. In the year April 2021 to March 2022, there had been one complaint. This was investigated and closed in a timely manner in line with the complaints policy. Action was taken in response to complaints received to help improve women's experience and service provision. For example, the complaint was around the delay for a scan over the Christmas period. The registered manager discussed this with the laboratory to ensure they booked appointments that would meet patient's timescales.

The induction programme included dealing with complaints, which all staff had completed. All staff knew who to contact if they received a complaint.

Are Community health services for adults well-led?

Outstanding ☆

Our rating of well-led stayed the same. We rated it as outstanding.

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 and take on more senior roles.

There was compassionate, inclusive and effective leadership at all levels. The registered manager led the service and was also the director of the business. The leadership they provided was supported by an experienced consultant and highly qualified team. The registered manager was a GP with previous experience managing an NHS recurrent miscarriage service. The consultant was an expert in early pregnancy.

The registered manager wanted to spend more time with patients and had increased the staffing to include a practice manager to enable them to do this. The practice manager was being supported to develop their skills to eventually become the registered manager.

Outstanding ☆

Community health services for adults

The registered manager had an in-depth understanding of the service's performance, challenges, and priorities. They had insight of wider developments in diagnostic and ultrasound practice. They were also aware of the actions needed to address those challenges. For example, challenges they faced included preventing staff burnout due to dealing with emotionally demanding situations; they did this sensitively by nurturing staff to ensure low turnover.

A member of staff described the registered manager as "incredibly supportive, approachable and very effective." One member of staff was leaving, and their feedback included, "Thank you for the last 18 months. It really is such a lovely service you offer and hope it continues to grow from strength to strength. It really has been a pleasure working with such lovely ladies and I have learnt so much."

Staff felt confident to discuss any concerns they had with the registered manager. They felt able to approach the registered manager directly, should the need arise.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans for the development of the service. The registered manager developed the business strategy using a structured planning process in collaboration with staff, people who use services, and external partners. The registered manager was working with other providers to provide additional services, including after miscarriage health checks.

The service was also considering alternative clinic locations in the area to accommodate weekend/evening opening. The registered manager was discussing with healthcare insurers to become a recognised provider for gynaecology scans.

The service had clear values which were focused on providing a first-rate service. Staff told us the values were "to give the best possible service." The registered manager told us, "We're always working with full empathy on how our clients feel on entering and leaving our clinic, making sure we're treating everyone equally with dignity and with respect."

The registered manager told us the ethos for the service was to provide the highest possible standards of service and care every time. They were passionate about treating women with empathy and understanding and led staff to make everyone's experience the best it could be. Feedback from women overwhelmingly praised staff for the friendly and supportive environment that surrounded them. Everyone we spoke with confirmed this and said they would highly recommend the service.

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.

Leaders had an inspiring and shared purpose and strived to motivate staff to succeed. The registered manager set high standards of caring for staff and told us they nurtured staff to ensure low turnover. This also enabled them to build on the experience in the team.

Staff were given opportunities to develop their careers. For example, one member of staff trained students of radiography and obstetric registrars how to scan. They had received awards for their work in early pregnancy. There were high levels of satisfaction among staff with a strong organisational commitment and effective action towards ensuing equality. Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff we met were friendly, welcoming and confident.

Staff told us they felt supported, respected, and valued by their managers. They enjoyed coming to work and were proud to work for the service. Staff told us there was strong collaboration, team-working and support between staff and a common focus on improving the quality and sustainability of care and people's experiences. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this process. Staff completed equality and diversity training. Staff were encouraged to raise concerns openly and without fear of recrimination.

Governance

Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The registered manager completed quarterly reports which summarised the activity of the service. These reports provided detailed statistical data which enabled managers to closely monitor and review the performance of the service. Results from recent audits reported in the January 2022 report showed staff achieved 100% in consent for sharing information, room cleaning (including extra cleaning due to COVID-19 precautions), probe cleaning and hand washing.

Staff provided a quality, safe service. The consultant provided clear guidance for sonographers to ensure scans identified any concerns. For example, staff were trained in the importance of scanning the area around the uterus because although rare, an ectopic pregnancy can occur alongside an intrauterine pregnancy. Staff were also trained to identify, for example, if women had cysts in their ovaries. This is important because if the ovary twists this can cause serious problems. This was balanced against the need to limit the duration of the ultrasound scan. The standards expected were clearly identified.

We found a clear line of governance to communicate information throughout the service, and to escalate and cascade information up and down lines of management and staff. Staff were clear about their roles and understood what they were accountable for and to whom. Staff could describe the governance processes for incidents and complaints and how they were investigated.

The registered manager had an information governance policy which staff were aware of. The registered manager followed national guidance from organisations such as the Society and College of Radiographers, British Medical Ultrasound Society, General Medical Council (GMC), the Nursing and Midwifery Council (NMC) and the Government gateway when drafting and reviewing policies.

The consultant had an ongoing interest in clinical audit and research at both local and national level.

The registered manager provided feedback to staff through appraisals and quarterly staff meetings. Staff also benefitted from one-to-one meetings with the registered manager. The registered manager provided feedback to staff about any complaints, incidents, women's feedback, performance, compliance with policies and procedures and any policy changes, any clinic issues, staffing and rotas in team meetings. Typical agendas included the quarterly reports and audits, significant events, relevant training and outstanding actions which included the audits needed for the next quarter.

The registered manager had a recruitment and training policy, which was last updated in April 2021. This stated all staff had to have a Disclosure and Barring Service (DBS) check before starting their employment at the location. All staff had an up-to-date DBS check. We reviewed all five personnel files and all staff had proof of identification, residence, and an up-to-date curriculum vitae on file. The service had obtained two references for all staff in line with their policy. We also saw employment offer letters, evidence of induction training, qualifications, and professional memberships were kept on file.

Management of risk, issues and performance

An effective system of quality assurance checks at service and provider level ensured continuous development and improvement of people's care. Staff identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Staff improved service quality and safeguarded high standards of care by creating an environment for excellent service to flourish. All staff were fully committed to patient safety.

The registered manager had a rigorous and reliable audit programme to provide assurance of the quality and safety of the service. Local audits, such as clinical and compliance audits were undertaken regularly. Data was collected by the registered manager to monitor performance. Quarterly quality and safety reports were written, summarising the number of scans and the outcomes of these. Where issues were identified, we saw these were and addressed quickly and openly. The reports also recorded significant events, such as women being incorrectly told by the GP practice receptionist that Somerset Early Scans were not located in the building. This had not prevented women from having their scans.

Sonographer peer review audits were undertaken in accordance with recommendations made by the British Medical Ultrasound Society and thorough feedback was provided. The registered manager completed annual sonographer competency assessments.

The service had a risk register where risks were documented, and actions were identified to manage each risk. The registered manager had completed risk assessments for identified risks such as COVID-19, harm to the fetus, and risk of needlestick injury to staff. A standard template was used to ensure consistent information was captured. The risk assessments identified who or what was at risk, the hazards and their potential effects, existing control measures in place, the risk rating, whether the risk was adequately controlled, and additional control measures needed. Most of the risks were graded low and had adequate controls to minimise each risk. Staff were aware of the risk assessments because they had been circulated to all employees and the management team. All risk assessments were reviewed at least twice annually or sooner if indicated.

The service had a clinic contingency plan with identified actions to be taken in the event of an incident that would impact the service. For example, extended power loss, severe weather events, short notice staff sickness and equipment failure. The contingency plan included contact details of relevant individuals or services for staff to contact.

Staff had both personal indemnity insurance and were also covered by the service's indemnity insurance.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

The service had policies and procedures to promote the confidential and secure processing of information held about patients. The information used in reporting, performance management and delivering quality care was consistently found to be accurate, valid, reliable, timely and relevant, having been scrutinised by all staff in quarterly quality and safety reports. Since our last inspection, the service had been updated to using electronic medical notes which meant it was easier to obtain second opinions on scans, share information and hold consultations by video link.

We saw appropriate and accurate information was effectively processed, challenged and acted upon. Key performance, audit, and patient feedback data was frequently collated and reviewed to improve service delivery.

The service was up-to-date with information governance and had data retention policies. These stipulated the requirements for managing patients' personal information in line with current data protection laws. The service was registered with the Information Commissioner's Office (ICO), which is in line with 'The Data Protection (Charges and Information) Regulations' (2018). The ICO is the UK's independent authority set up to uphold information rights.

Based on advice from the NHS information governance alliance, all pregnancy medical records and ultrasound images must be kept until 25 years after the birth of the last child. All healthcare records and ultrasound images and report for non-pregnant women must be kept for eight years until the date individuals were last seen. This information was clearly detailed in the terms and conditions of the service. Scan reports could be reviewed remotely by another sonographer to enable timely advice and interpretation of results when needed.

The service had ongoing maintenance of their website to ensure it provided clients with the best user experience, with up-to-date information and ease of navigation.

Engagement

There were consistently high levels of constructive engagement with staff and people who use services. The service engaged well with women, staff and the public to plan and manage appropriate services and collaborated with partner organisations effectively.

There were many examples that showed exceptionally personalised commitment and attention to women. This ranged from ensuring high-quality support, to visiting people in hospital when they were not well, ensuring they had access to things important to them or highly detailed support throughout their scans.

Staff were proactive identifying the topics women would need to ask questions about. The provider's website had monthly blogs completed by staff which addressed pregnancy and gynaecology related issues and concerns and provided an excellent source of information. Each month they focused on different topics and were written in an easy to

understand format. Throughout COVID-19 staff reassured women with posts such as 'Managing anxiety in pregnancy during the pandemic' and 'COVID-19 in pregnancy'. Other topics included, for example, health related matters such as diabetes and polycystic ovaries. The service also had a social media page where they shared similar topics and reached a wider audience by having the information in more than one location.

Women and their families were asked to provide feedback when they visited. The service also used social media and internet reviews to obtain feedback from women and their families. Feedback included, "Our sonographer was an absolute delight, fun and engaging and really reassuring" and, "The service was extremely professional but also really empathetic which made me and my partner feel really at ease, clearly lots of thought and experience has gone into the service provided."

The registered manager and sonographers had developed close working relationships with local NHS hospitals. Staff were able to quickly refer women to the appropriate service if any anomalies were detected. Feedback was requested on an annual basis from NHS early pregnancy units and midwifery/obstetric teams that women were referred to. Feedback requested included whether women expressed any positive or negative comments about the service and whether the communication from the service to the NHS service was of a high quality. Suggestions for improvement were reviewed by the registered manager and action taken if needed.

Staff maintained their registrations with relevant bodies, namely the General Medical Council, Nursing and Midwifery Council and Society of Radiographers and followed their codes of conduct.

Learning, continuous improvement and innovation

There was a fully embedded and systematic approach to improvement. The service was committed to improving services by learning from when things went well or wrong, and promoting training, research and innovation. All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

At the time of our inspection, the registered manager had been informed they were winners of a Prestige Award for the whole of the Southwest of England. They had been awarded the Ultrasound Clinic of the Year 2022 title which was being announced in May 2022.

The service were runners up in the Somerset Business Awards 2021 for "Service Excellence".

The registered manager operated a continuous improvement policy by analysing and understanding the feedback they received from all external stakeholders. As a result, they were able to shape and plan the service they offered because they took decisive action. The registered manager constantly reviewed actions taken to ensure the changes they brought about were best for women using the service.

The service demonstrated a strong commitment to professional development. The consultant had completed a research project in reassurance scanning in early pregnancy particularly focusing on women with a history of recurrent miscarriage. They presented materials at both national and international conferences. The registered manager had published many articles about women and new-born health and won several awards. One nurse practitioner has received several awards for their work in early pregnancy.

Outstanding ☆

Community health services for adults

The commitment to professional development included on-line and site based continuous professional development training for personal and professional growth for all staff. For example, enhanced training for delivering bad news was offered to staff, and we saw staff had attended this training organised in conjunction with a national conference.

Safe innovation was celebrated. There was a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of service delivery and care. For example, the service made use of an innovatively designed probe that tilted the beam, which provided better internal views of the top of the womb.

The registered manager was actively working towards increasing their gynaecology scans by becoming a recognised provider for a range of health care insurance providers. The type of scans the service provided included gynaecology scans such as checking women after suffering miscarriage and looking for cysts and polyps in the womb.