Bumpkins-York Limited

Bumpkins York

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

Our rating of this location stayed the same. 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. The service controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records.
- Staff provided good care to women that was based on an ethos of continuous improvement. The registered manager monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of women, supported them to make decisions about their care, and had access to good information. Key services were available flexibly.
- Women were respected and valued as individuals. Staff empowered them as partners in their care, practically and emotionally.
- The service planned care to meet the needs of people who used the service, took account of women's individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- The service had an overarching vision that focused on the needs of women who used the service. 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:

- The registered manager used Institute of Sonography and Gynaecology (ISG) national guidance to benchmark image quality but did not track or monitor this in an audit or equivalent.
- The registered manager planned to obtain peer review and supervision from other sonographers in the ISG network although this had not yet taken place.

We last inspected the service in October 2019. We told the service it should act to improve the tracking of policies and procedures through more consistent documentation of dates. We noted the ultrasound practitioner, who was also the registered manager, did not receive supervisions or peer reviews. At this inspection, we found the registered manager had improved the management of policies and had plans in place to establish peer review processes.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Good 	We rated this service as good because it was safe, effective, caring, responsive and well led.

Summary of findings

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Summary of this inspection

Background to Bumpkins York

Bumpkins York is operated by Bumpkins-York Limited. The service opened in September 2017 and is a single speciality independent healthcare provider offering 2D, 3D and 4D imaging to self-funding women who use the services.

The service provides non-invasive prenatal screening (NIPTS), early gender DNA testing, and ultrasound scanning for people aged 18 and over in relation to pregnancy (from ten weeks through to full term), including gender scans, and early bonding experiences.

Bumpkins York was staffed by an ultrasound technician, who was the registered manager, and an office manager.

The centre is registered to provide the following regulated activities:

- Diagnostic and screening procedures

The service has a registered manager in post.

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. The inspection was overseen by Sarah Dronsfield, Head of Inspection. 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.

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

Outstanding practice

We found the following outstanding practice:

- The service provided compassionate and flexible services when this was meaningful for women and their families. They had opened a late night clinic for a woman whose grandparents wanted to see a live scan around treatment for a terminal condition. Staff had arranged for printed scan images to be placed in the coffin of a woman's relative when they were buried.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the provider SHOULD take to improve:

Summary of this inspection

- The service should consider a more structured approach to auditing image quality as a tool for continuous improvement.
- The service should expedite plans for a peer review and supervision schedule.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Diagnostic and screening services

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

Are Diagnostic and screening services safe?

Good

Our rating of safe stayed the same. We rated it as good.

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. Mandatory training was comprehensive and met the needs of women and staff.

Two members of staff operated the service and worked together to ensure their training was up to date. This included infection control, safeguarding, and health and safety.

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 undertook training specific for their role on how to recognise and report abuse and could give examples of how to protect women from harassment and discrimination. Both members of staff maintained level three adult and child safeguarding training.

Staff provided examples of when they had acted on safeguarding concerns. Their actions had protected women from potential harm, including in instances where they suspected domestic abuse.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. They adhered to a safeguarding policy that required online bookings to be made at least 24 hours in advance. If someone tried to make a booking with less notice, the service required a telephone conversation with the individual to ensure they met safe scanning criteria and were not under coercion or duress.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The registered manager maintained up to date information for the local safeguarding team and had established links with safeguarding leads at local NHS trusts in the event of an urgent referral.

Good

Diagnostic and screening services

Staff followed safe procedures for children visiting the service and all waiting areas were modified for child safety

Discreet signage in the clinic let women know they could ask for private space to talk with staff and the service displayed information on how to get help for domestic violence.

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 used a daily infection prevention and control checklist to ensure all areas were cleaned and sanitised on days the clinic was open. They used a weekly checklist for deep cleans of clinical areas.

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

Staff followed infection control principles including the use of personal protective equipment (PPE). The sonographer used appropriate antibacterial wipes to clean and decontaminate surfaces, including the ultrasound probe, between each scan.

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 design of the environment followed national guidance. Scanning and blood tests took place in a clinical room that met Department of Health and Social Care national guidance on the clinical environment.

Staff carried out daily safety checks of specialist equipment. Service agreements were in place for annual planned servicing and a call-out plan was in place in the event of equipment failure.

The manager stored phlebotomy equipment in a locked unit with restricted access. The organisations that operated laboratories for early gender DNA testing and non-invasive prenatal screening (NIPTS) supplied equipment and disposed of expired items on demand.

The service had suitable facilities to meet the needs of women's families and the service had enough suitable equipment to help them to safely care for women.

Staff disposed of clinical waste safely. The service had a contract with a third party organisation to collect and dispose of hazardous waste. The service was fully compliant with the Department of Health and Social Care health technical memorandum and the Health and Safety Executive Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 in relation to sharps waste. The clinical waste disposal contract included the disposal of sharps waste.

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.

Good

Diagnostic and screening services

Staff responded promptly to any sudden deterioration in a patient's health. Both members of staff were trained in first aid and the clinic had a first aid kit and biological spill kit. The registered manager and sonographer maintained level three paediatric first aid training. This reflected good practice as children regularly accompanied parents to the clinic.

Staff completed risk assessments for each woman at the point of booking. This included a check of relevant medical history and a check of their age and registration on an NHS maternity pathway. The service required a pregnancy to be at least 10 weeks before they could scan and ensured women provided this information before a scan. This enabled the service to ensure patients were safe for scanning.

Staff used a three-point ID check for each woman prior to commencing a scan. This was a safety check in line with national standards.

NIPTS was used as a preventative measure to help identify early pregnancy risks. The service carried out blood tests for the screening and arranged for a courier to transport the sample to a laboratory for testing. Staff carried out a risk assessment and consent process for women who requested this service to ensure they understood results and onward care signposting was provided by a third party organisation. This ensured there was clear separation of each responsibility for the providers involved.

Staffing

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

The registered manager was the sonographer and owner of the business. An office manager supported them and provided reception, booking, and other administrative and operational support duties. Both members of staff were trained appropriately for the care provided and worked together to meet demand.

Both members of staff had up to date Disclosure Barring Service (DBS) checks and the registered manager updated these every three years.

At the time of our inspection there were no bank, agency, or locum staff in post. The service had previously employed locum sonographers during periods of high demand and maintained a policy for a full background check and induction.

Records

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

Scan notes were comprehensive, and staff could access them easily. The service provided simple gender scans only and did not offer a diagnostics service. Scan reports reflected this.

In the event the sonographer found sinister pathology or evidence of a miscarriage, they provided a detailed report to the nearest early pregnancy assessment unit (EPAU), or to the nearest emergency department. Women consented to this in advance of a scan.

Records were stored securely. The service operated on a paperless model and all scan imagery and data was stored in a secure digitally encrypted system. The platform provided storage solely for medical scan organisations and had back-up protocols in place for systems failures.

Good

Diagnostic and screening services

Medicines

The service did not store, manage, prescribe, or dispense medicines.

Incidents

The service had systems in place to manage safety incidents. Staff recognised and knew how to report incidents and near misses.

Staff knew what incidents to report and how to report them. The registered manager maintained an up to date incident management policy and a record system for incidents. We discussed this with both members of staff during our inspection and were assured they understood this system and the importance of the process. They had not documented any incidents in the previous 12 months.

The registered manager monitored incidents and shared learning from similar services nationally to remain up to date with current practice.

Staff understood the duty of candour. The service's incident management policy included the duty of candour and the registered manager said they would be responsible for implementing this.

Are Diagnostic and screening services effective?

Inspected but not rated

We do not currently rate effective for baby scan services.

Evidence-based care and treatment

The service provided care and procedures based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The registered manager maintained policies and standard operating procedures and reviewed these regularly. They documented review dates, highlighted key changes, and shared changes with the office manager.

The registered manager and sonographer was a member of the Institute of Sonography and Gynaecology (ISG) and had access to updates to best practice and national guidance. They benchmarked policies and procedures with ISG standards.

The registered manager regularly reviewed guidance and alerts from the National Institute for Health and Care Excellence (NICE) and the British Medical Ultrasound Society (BMUS). This meant care was in line with the latest understanding of best practice. The service subscribed to the BMUS 'as low as reasonably achievable' (ALARA) protocols. This meant the sonographer used the lowest possible output power and shortest scan times possible consistent with achieving the required results.

Patient outcomes

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

Good

Diagnostic and screening services

Outcomes for women were positive, consistent and met expectations, such as national standards. The sonographer used national guidance to deliver scans and measured outcomes against women's expectations. Where clear scan images could not be achieved, the sonographer gave women time for a break to help the movement of baby. If this did not improve the scan, the service rebooked for a later date.

Managers and staff used the results to improve women's outcomes. The registered manager actively sought feedback from the local NHS trust following referrals to the early pregnancy assessment unit (EPAU) or the emergency department. This occurred in cases where they found or suspected a miscarriage or other urgent finding. This helped to ensure their practice was in line with the standards of other regional health services.

The registered manager benchmarked the quality of scan images against ISG standards although this was not yet audited by another sonographer.

Competent staff

The service made sure staff were competent for their roles.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women.

Two members of staff operated the business and delivered the service. They maintained clear definitions of roles and responsibilities and worked together daily. This meant formal supervisions were rarely needed and instead they proactively discussed issues affecting the service, training needs, and ideas for improvement.

The service had not recruited new staff for some time and had an up to date induction policy in the event recruitment took place.

The registered manager and sonographer said they planned to obtain peer support and review from the ISG although this system was not yet in place. They had access to specialist training from that organisation and maintained competencies commensurate with their role and the services offered, such as level three advanced phlebotomy.

Multidisciplinary working

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

Staff worked across health care disciplines and with other agencies when required to care for women. They provided referrals to the neonatal unit or EPAU at nearby NHS trusts when scans revealed unexpected findings. They contacted the EPAU whilst the individual was still in the scanning unit and provided them with the instructions provided by the trust before they attended.

If the sonographer was unable to obtain a clear scan image and was concerned about the reasons for this, they referred women to the EPAU. The sonographer provided a detailed report in advance.

Seven-day services

Services were available to support timely patient care.

The service operated on a flexible appointment basis seven days per week, with evening appointments on request. The online booking system was available 24/7.

Good

Diagnostic and screening services

Health promotion

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

The sonographer provided ad-hoc advice to women on healthy pregnancies, such as how to achieve good standards of nutrition and exercise.

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.

Staff gained consent from women for their care and treatment in line with legislation and guidance. The booking form required women to give signed consent and staff reviewed this when they arrived in the clinic. Consent processes were tailored to individual bookings. For example, heartbeat scans required both the sonographer and the office manager to be present to carry out the process effectively. Women consent to this in advance.

The service required women to have had initial maternity reviews with an NHS trust and to be at least 10 weeks into a pregnancy before scanning. Women declared this during the booking process and staff then sought consent to notify the NHS service of scan results where sinister pathology or other concerns were found.

Staff said if a woman could not consent, or they were not assured a woman understood what they were providing consent for, they would not proceed with a scan.

Staff clearly recorded consent in the women's records. This was captured in the online booking process specifically in relation to the type of scan booked, such as the minimum pregnancy period for each type of scan.

Staff received and kept up to date with training in the Mental Capacity Act as part of safeguarding training. They understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act.

Are Diagnostic and screening services caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. We saw staff offered a warm, personal, and friendly welcome to everyone who came into the clinic, including partners and children accompanying women for a scan. Staff were confident and compassionate and put everyone at ease. We observed staff adapt their communication approach based on each woman and their family, which resulted in tailored, discreet standards of care.

Good

Diagnostic and screening services

Women said staff treated them well and with kindness. The service frequently received written feedback from women and their partners who were happy with the service. One person noted, “Thank you so much for what you do, you have made so many memories for us.” Another person wrote, “Thank you for the fantastic service, you have gone above and beyond.”

Staff followed an up to date policy to keep patient care and treatment confidential.

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 was located nearby to a traveller population and had adapted elements of care, such as the booking process, to meet the specific needs of women from this community. Staff worked with the local NHS trust to obtain guidance on safeguarding measures for women in this community.

The service recognised the need for compassionate care above and beyond a scan. For example, they had provided printed scan images of a woman’s pregnancy to be placed in a loved one’s coffin when they died before the birth.

Emotional support

Staff provided emotional support to women, families and carers to minimise their distress.

Staff gave women and those close to them help and emotional support when they needed it.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. The clinic had private space available and waiting families were separate from those being scanned to facilitate more space in the event of an emotional conversation.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. They recognised the emotional impact of learning the gender of a baby and provided women with a gift after each scan. This promoted a positive approach to the scan and was presented in a ‘congratulations’ box. Staff marked the box with gender-neutral labelling where the individual did not yet want to know the gender.

If the sonographer identified a miscarriage or foetal death, they did not release the scan images to the woman or their family and referred them either to an emergency department or the early pregnancy unit depending on the urgency of need. This ensured women received immediate emotional support.

Staff provided earbuds and played music during scans or blood tests if women reported feeling anxious.

Understanding and involvement of women and those close to them

Staff supported women and families 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 provided printed or electronic information to women ahead of scans and blood tests. This helped them to contribute to good scan quality with advice such as to keep well hydrated and warm ahead of the process. The information was visual and designed to be easy to understand.

During scans we observed, the sonographer explained to women what they were doing and helped them to understand the images on the screen. They supported women to move into other positions to optimise the scan images.

Good

Diagnostic and screening services

Staff talked with women, families and carers in a way they could understand. We observed staff speak with patients clearly and with discretion. They made sure they fully understood each woman's requests and needs before proceeding with a scan.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. Women gave positive feedback about the service. One person noted in feedback, "Thank you so much for your kindness, patience and professional nature." Women were emphatic and positive in their feedback, which included comments such as, "Best experience ever", and "Absolutely fantastic." Women commented on the environment. One person said, "Setting is calm and professional and very welcoming."

Are Diagnostic and screening services responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of people

The service planned and provided care in a way that met the needs of people and the communities served.

The service planned and organised services to meet the changing needs of the local population. The service provided transabdominal scans for women aged 18 years and above. Staff said they frequently received requests from younger women for scans and referred them to registered services equipped for younger people.

The service provided early gender DNA tests and non-invasive prenatal screening (NIPTS). This is a preventative test to identify early risks to pregnancy. The sonographer was a trained phlebotomist and took a blood sample in the clinic, which was then sent by courier to a laboratory. After this process, women dealt with the laboratory and any onward care was provided by the NHS or independent hospital. The service ensured women understood this information in advance of carrying out the blood test. At the point of testing, the laboratory for NIPTS provided each woman with a named point of contact for the rest of the process.

The service minimised the number of times women needed to attend the clinic, by ensuring women had access to the required staff and tests on one occasion. For example, they offered scans and DNA or non-invasive prenatal screening (NIPTS) in the same appointment as the scan. If the sonographer could not get a clear scan because of the baby's position, they offered women time to walk around and try again.

Facilities and premises were appropriate for the services being delivered. The service was delivered in purpose-built premises with a dedicated scanning room and comfortable waiting area for women and their loved ones. Children's toys were available for those accompanying women. All areas were accessible by those with mobility restrictions or who used a wheelchair.

The service had systems to help care for women in need of additional support or specialist intervention. Staff recognised the vulnerabilities of different individuals and communities and kept up to date with details for local specialist organisations. They provided onward referral or signposting and supported women to access help.

Staff monitored and took action to minimise missed appointments. They contacted women 24 hours in advance to remind them of the appointment and offered time to ask any questions they had about the process.

Good

Diagnostic and screening services

Staff ensured that women who did not attend appointments were contacted. At the point of booking women provided their preferred contact details and staff used these to reach them in the event they did not attend. Staff said they would refer to the local safeguarding team if they had concerns about a woman's welfare.

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.

The whole ethos of the service was to meet individual needs. The registered manager understood the importance and personal significance of gender baby scans and tailored the service to each individual woman and their loved ones.

Some women wanted a scan to reveal the gender but to keep this information secret for a family event or gender reveal party. In such cases, the sonographer ensured screens were facing away from the woman during the scan so they could not see the gender. The office manager then provided a gender-neutral gift that would reveal the gender only when opened.

Staff ensured they fully understood each women's needs and preferences before a scan. This information was collected through the online booking form and staff reconfirmed it when the baby arrived. Where women were undecided as to whether they wanted to know the gender, the sonographer worked with them to provide support during the process and ensure they made the right decision for them.

The service had information leaflets available in languages spoken by the women and local community. Staff asked women at the point of booking if they needed language support or communication support relating to visual or hearing impairment.

After scanning, the service provided printed and digital scan images to women. Digital images were available through a secure app, which women had access to shortly after the scan. This enabled them share images as they saw fit.

Access and flow

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

Managers worked to keep the number of cancelled appointments to a minimum. There had been no instances of the service cancelling scans and the only cancellations occurred when women presented outside of the safe scanning term of their pregnancy. The pre-screening process was designed to avoid this, but the service found sometime women provided inaccurate information that meant they could not scan.

The online booking system and the service website clearly stated the minimum pregnancy terms for different scans, such as 16 weeks for a heartbeat scan. Women had to acknowledge these details before proceeding to book. Where women arrived and had given inaccurate information, staff rebooked appointments for the safe time frame.

The registered manager delivered services on demand to meet special requests and individual needs. For example, they had facilitated an out of hours scan so that a person's grandparent could attend around critical medical treatment.

The service pre-booked courier collection for blood samples for NIPTS and early gender DNA tests. This ensured samples reached the laboratory within the timeframe needed for an effective scan.

Good

Diagnostic and screening services

Staff offered a flexible scanning service to fit around women's other commitments, including weekend and evening scans.

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.

Women, relatives and carers knew how to complain or raise concerns. Information about the complaints process was on display in the clinic and accessible on the service's website.

Staff understood the policy on complaints and knew how to handle them. There had been no complaints in the previous 12 months and all feedback was positive.

Are Diagnostic and screening services well-led?

Good

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

Leadership

The registered manager had the skills and abilities to run the service.

The registered manager was the business owner and the sonographer. Along with the office manager, manager and their colleague, the office manager, they understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and their families.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on the sustainability of the service.

The registered manager had developed objectives for the business and quality aims for the standard of care. They had also implemented a business continuity plan, which reflected the nature of the service.

Culture

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

We observed a mutually respectful and supportive culture between the two members of staff. Both individuals were demonstrably passionate about their work and the standard of care provided and worked tirelessly to meet individual needs.

Staff spoke openly with women about the scans with the best results for their stage of pregnancy and planned outcomes. They provided advice when women requested scans that would not result in optimum images as part of an ethos of transparency.

Good

Diagnostic and screening services

Governance

The registered manager operated effective governance processes. Staff were clear about their roles and accountabilities and worked closely together.

The registered manager had developed clear governance protocols that reflected the nature of the service. For example, while they carried out blood tests for non-invasive prenatal screening (NIPTS), an independent laboratory was responsible for screening, providing results, and following up with each woman. The service had a standard operating procedure for this and made sure women fully understood it before agreeing to carry out NIPTS. Similarly, the service made it clear scanning was not diagnostic by nature and that women's maternity care remained with the NHS.

Appropriate policies and procedures were in place. These were signed and dated, and the registered manager used a rolling programme of review to ensure they remained up to date.

Management of risk, issues and performance

The registered manager used systems to manage performance effectively. They identified and acted on relevant risks and issues. They had plans to cope with unexpected events.

The service provided non-diagnostic gender scans for bonding purposes only and did not offer information or advice on pregnancy viability or diagnostics. This information was presented to women during the booking process and was the basis of consent. Staff ensured women fully understood this before a scan or blood test took place.

The registered manager maintained a document of risks that reflected the nature of the service. They noted controls for each risk and documented changes and reviews.

Staff occasionally worked alone in the clinic and followed a risk assessment and policy for this. The clinic was co-located on the owner's other business property and the risk process meant someone nearby was always available by phone. The member of staff made sure a named person knew the time and expected finish time of an appointment.

Information Management

Information systems were integrated and secure.

The service had an up to date information and data management plan that incorporated confidentiality and the General Data Protection Regulations (GDPR). The service managed most data using secure cloud-based systems. This included the use of an app for women to access their scan images. Scan images remained the property and responsibility of the service and electronic transmission took place only to enable women's access.

The registered manager archived images as part of a policy to ensure they had access to information in the event of a future complaint or investigation.

Engagement

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

The online booking system ensured women had access to comprehensive information in advance of a scan. This included minimum pregnancy terms for each type of scan and detailed information on the differences between scans, expected results, and clear costing.

The online booking system automatically contacted women after each scan to ask them for feedback. The service maintained a consistently good survey completion rate of 30% and a maximum five star rating, including for those who would recommend the service.

The registered manager and office manager had worked to build good working relationships with NHS trusts in the region. This helped to improve understanding of the differences in their respective services and break down preconceptions about private baby scan services. This engagement resulted in good relationships with NHS services such as early pregnancy assessment units (EPAUs) and neonatal services, which promoted good access for women if the sonographer referred them.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The service had recently relocated to new premises following feedback from women about access. This enabled staff to offer a more private, dedicated, spacious environment that was welcoming and comfortable.

The registered manager was committed to exploring the use of new technology to improve women's experiences and offer new services. They had invested in new ultrasound equipment to offer state of the art 4D scans with cloud-based access to images to help women share them with loved ones.