# Preview Baby Limited

## Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

## Ratings

| | |
|---|---|
| Overall rating for this location | Good |
| Are services safe? | Good |
| Are services effective? | |
| Are services caring? | Good |
| Are services responsive? | Good |
| Are services well-led? | Good |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Preview Baby Limited is operated by Preview Baby Limited. The service provides diagnostic pregnancy and fertility ultrasound services, and obstetric screening services to self-funding women across Hertfordshire and its surrounding areas.

We inspected this service using our comprehensive inspection methodology. We carried out a short-notice announced inspection on 29 January 2019. We gave staff two working days' notice that we were coming to inspect to ensure the availability of the registered manager and clinics.

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.

**Services we rate**

We have not previously inspected this service. At this inspection, we rated the service as **good** overall.

We found areas of good practice:

- Staff understood how to protect people from abuse, and the service worked well with other agencies to do so.
- The service had appropriate arrangements in place to assess and manage risks to women, their babies, and families.
- Women were supported to make informed decisions about their care. Staff understood how and when to assess whether a woman had the capacity to make decisions about their chosen care. Staff were aware of the importance for gaining consent from women before conducting any ultrasound scan or screening service.
- The service had effective arrangements in place for identifying and recording risks. The risks and their mitigating actions were discussed with the wider team.
- Staff were caring, kind and engaged well with women and their families. The directors promoted a positive culture that supported and valued staff. Staff confirmed they felt respected and valued.
- The service used current evidence-based guidance and good practice standards to inform the delivery of care and treatment. Staff demonstrated a good understanding of the national legislation that affected their practice.
- Preview Baby Limited had a clear vision and strategy for what they wanted to achieve, with quality and sustainability as the top priorities.

However, we found the following areas of practice that the service needed to improve:

- While most of the governance arrangements were clear and appropriate to the size of the service, there were not effective recruitment processes in place to assess sonographer competence and suitability for their role. However, this was addressed immediately after our inspection, and the directors reviewed and updated their current recruitment requirements.
- Peer review audits were not completed in line with national guidance. However, following our inspection, a rolling audit programme was introduced.

# Summary of findings

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

**Amanda Stanford**
**Deputy Chief Inspector of Hospitals (Central)**

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Diagnostic imaging** | Good | The provision of ultrasound scanning services, which is classified under the diagnostic core service, was the only core service provided at Preview Baby Limited. We rated the service as good overall because there were processes in place for the escalation of unexpected findings during ultrasound scans. Feedback from women and their families was extremely positive. Women could access services and appointments in a way and at a time that suited them, women had timely access to treatment, and the directors of the service had the appropriate skills and experience to manage the business. However, at the time of our inspection, there were not effective recruitment processes in place, and peer review audits were not completed in line with national guidance. This was addressed immediately after our inspection. |

# Summary of findings

## Contents

Good

# Preview Baby Limited

**Services we looked at:**
Diagnostic Imaging.

# Summary of this inspection

## Background to Preview Baby Limited

Preview Baby Limited is a private diagnostic service based in Hitchin, Hertfordshire, and is operated by Preview Baby Limited. It was established in June 2017, and provides pregnancy and fertility ultrasound services and obstetric screening services to self-funding women, aged 18 years and above. All ultrasound scans performed at Preview Baby Limited are in addition to those provided through the NHS.

The service is registered with the CQC to undertake the regulated activity of diagnostic and screening procedures. It has had a registered manager in post since registering with the CQC in June 2017.

We have not previously inspected or rated this service.

## Our inspection team

The inspection team was comprised of one CQC lead Inspector and one Assistant Inspector. The inspection team was overseen by Jo Naylor-Smith, Inspection Manager, and Bernadette Hanney, Head of Hospital Inspection.

## Information about Preview Baby Limited

Preview Baby Limited is located on the ground floor, with easy access for wheelchair users. The service is sonographer-led and provides diagnostic pregnancy ultrasound and screening services to women aged 18 years and above. It also offers fertility ultrasound scans, which are performed by a consultant obstetrician and gynaecologist.

Their services include:

- Early pregnancy scans performed from six to 12 weeks' gestation.
- Dating scans performed from 12 to 16 weeks' gestation.
- Harmony scans and non-invasive prenatal testing (NIPT) (a scan and a blood test to determine the baby's risk of genetic conditions) performed from 10 to 24 weeks' gestation.
- Nuchal translucency scans (a scan and a blood test to determine the baby's risk of Down's Syndrome) performed from 11 to 13+6 weeks' gestation.
- Reassurance scans performed from 14 weeks' gestation.
- Cervical length scans (used to help identify premature labour) performed from 16 to 40 weeks' gestation.
- Gender scans performed from 16 to 32 weeks' gestation.
- Anomaly scans (used to look at the anatomical structures of the baby, including the head, chest, and heart) performed from 19 to 24 weeks' gestation.
- Growth scans performed from 24 to 36 weeks' gestation.
- Presentation scans performed from 37 to 40 weeks' gestation.
- 4D bonding baby scans performed from 25 to 32 weeks' gestation.
- Scans before and during fertility treatment, including ovulation scans.

All women accessing the services self-refer to the clinic and are all seen as private (paying) patients.

There are two fertility clinics and four pregnancy clinics per week. Standard operational hours for the pregnancy

# Summary of this inspection

clinics are Monday, Wednesday, and Friday evenings from 6 to 9pm, and every Saturday from 10am to 4pm. The fertility clinics are held every Tuesday and Thursday by appointment only.

At the time of our inspection, four sonographers and one phlebotomist/receptionist were employed on a bank basis (as and when they were needed). A consultant obstetrician also worked at the service under practising privileges, and ran the fertility service. In addition, there were two directors, including the registered manager who was a practising midwife. The other director was a qualified phlebotomist. The service did not use controlled drugs (CDs).

During our inspection, we visited the registered location in Hitchin, Hertfordshire. We spoke with four staff members, including the directors and sonographers. We also spoke with two women, and reviewed four patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

Activity:

Preview Baby Limited performed a total of 1,264 ultrasound scans from January to December 2018. A breakdown of the type of scan can be seen below:

- 382 (30%) early pregnancy scans.
- 22 (2%) dating scans.
- 386 (31%) gender scans.
- 73 (6%) NIPT and harmony scans.
- Eight (0.6%) nuchal translucency scans.
- Four (0.3%) cervical length scans.
- 150 (12%) reassurance scans.
- Nine (0.7%) anomaly scans.
- 30 (2%) growth scans.
- Eight (0.6%) presentation scans.
- 172 (14%) 4D baby bonding scans.
- 12 (1%) gynaecology scans.
- All women were self-funded.

For the reporting period of January 2018 to December 2018, Preview Baby Limited did not cancel any patient appointments due to non-clinical reasons. Similarly, for the same reporting period, no ultrasound scans were delayed due to non-clinical reasons.

Track record on safety:

- The service reported zero never events from January to December 2018.
- The service had not recorded any incidents from January to December 2018.
- The service reported zero serious injuries from December 2017 to November 2018.
- The service received zero complaints from January to December 2018.
- Preview Baby Limited reported zero incidents of health associated MRSA, Methicillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (C. diff), and Escherichia Coli (E-Coli).

# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Diagnostic imaging | Good | N/A | Good | Good | Good | Good |
| Overall | Good | N/A | Good | Good | Good | Good |

**Notes**

We do not rate effective.

Good

# Diagnostic imaging

| | |
|---|---|
| Safe | Good |
| Effective | |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |

## Are diagnostic imaging services safe?

Good

We have not previously inspected this service. At this inspection, we rated safe as **good.**

**Mandatory training**

- **Staff had completed mandatory training in key skills.**
- The consultant obstetrician, registered manager and sonographers had completed mandatory training at their substantive NHS employment.
- The service had oversight on what training these individuals had completed, and this was reviewed by the directors on an annual basis. The completed training modules included: equality and diversity, basic life support, information governance, fire safety awareness, consent and mental capacity, infection prevention and control, safeguarding adults, and safeguarding children training.
- As of January 2019, all six individuals were compliant with their required training modules.
- The other director accessed external mandatory training courses. At the time of our inspection, they had completed health and safety training, first aid at work, and fire warden training.

**Safeguarding**

- **Staff understood how to protect people from abuse, and the service worked well with other agencies to do so.**
- All staff we spoke with had a comprehensive understanding of their responsibilities with regards to recognising and reporting potential abuse. They could describe the steps they would take if they were concerned about the potential abuse of their clients or visitors. This included informing the safeguarding lead for the service.
- There was an up-to-date safeguarding adult and children policy for staff to follow, which included the contact details of the local safeguarding boards. The contact numbers were also displayed in both clinic rooms.
- The safeguarding policy also provided staff with clear guidance on how to identify and report female genital mutilation (FGM). If staff were concerned about any woman, they would refer to the local safeguarding team.
- The service had a designated lead for both children and adults' safeguarding, who was the registered manager. They were available during working hours to provide support to staff, and had completed both adult and children's level three safeguarding training.
- The service had established good working relationships with the local NHS hospitals. If staff needed any safeguarding advice, they would contact the safeguarding team at the hospitals for guidance, this included a level four children's safeguarding trained professional.
- The sonographers did not receive safeguarding training from Preview Baby Limited as they completed this training at their substantive NHS employer. We found that all four sonographers were compliant with safeguarding adults training level two, which was the level appropriate to their role.

- Although Preview Baby Limited, did not provide ultrasound services to adolescents under the age of 18 years, children frequently attended ultrasound scan appointments with their mothers. From review of the staff files, we saw that all four sonographers had received safeguarding children's training level two. This met the intercollegiate guidance 'Safeguarding children and young people: roles and competencies for health care staff' (March 2014).
- At the time of our inspection, the service did not have a copy of the safeguarding training certificates for three staff members. Following our inspection, the directors provided evidence which showed that the three individuals had completed both level two adults' and children training. This meant that safeguarding training was in accordance with national legislation.

**Cleanliness, infection control and hygiene**

- **The service controlled infection risk well. Staff kept themselves, the equipment, and the premises clean.** The clinic rooms, toilet, reception and waiting areas were visibly clean and clutter free on the day of our inspection.
- Preview Baby Limited had infection prevention and control (IPC) policies in place, which provided staff with guidance on appropriate IPC practice.
- Cleaning was recorded on daily and weekly check sheets, which were completed by the directors. We reviewed the cleaning checklists and saw cleaning had been consistently completed.
- Flooring throughout the clinic was well maintained and visibly clean. Flooring in the procedure and recovery rooms was in line with national requirements ('Health Building Note 00-10 Part A: Flooring', Department of Health, 2013). The reception area was carpeted; however, no clinical procedures were carried out in this room. This meant there was very little risk of infection from blood or other bodily fluid spillages.
- A spillage kit was available and stored securely within the service. Information relating to the control of substances hazardous to health (COSHH) regulations was also available, and contained relevant details to ensure those using chemicals could do so safely.
- The sonographers followed the manufacturer's and IPC guidance for routine disinfection of equipment. Staff decontaminated the ultrasound equipment with disinfectant wipes between each woman and at the end of each clinic. They applied 'I am clean' stickers to the ultrasound machine following their clinic to indicate it was clean and ready to use.
- Disposable paper towel was used to cover the examination couch during the scanning procedure. This was changed between each woman.
- Tourniquets used during venepuncture were single patient use only. This eliminated the risk of cross patient contamination from re-used equipment. A tourniquet is a mechanical device used for the temporary control of the circulation of blood.
- A supply of personal protective equipment (PPE) was available and accessible to all staff, including gloves and aprons. Staff described how they used the PPE when interacting with women. They also explained they would have their 'arms bare below the elbows' in clinical areas. This helped to prevent the transfer of infection from clothing that could be contaminated, and allowed them to wash their hands thoroughly.
- There were suitable handwashing facilities available, which included handwashing basins and sanitiser gels in the clinic rooms and toilet. Staff told us they washed their hands before and after each patient contact. The World Health Organisation's (WHO) 'Five moments for Hand Hygiene' posters were displayed above every handwashing basin.
- Hand hygiene audits were undertaken to measure the phlebotomists' compliance with the WHO hand hygiene guidance. Formal hand hygiene audits were not completed for the sonographers as the directors felt this would impact on women's privacy and dignity during their ultrasound scans.
- We reviewed the last three hand hygiene audits, and found that no concerns were identified.
- There were appropriate arrangements in place to reduce the risk of staff exposure to blood born viruses. The service's needle stick injury policy outlined what precautions the phlebotomists should take when taking blood, which included wearing appropriate PPE, not re-sheathing the needles, and ensuring

needle safety cover was used after the procedure. If a staff member sustained a needle-stick injury, they reported to the nearest emergency department and informed the registered manager.

- From January to December 2018, the service did not report any incidents of needle-stick injury.
- A risk assessment for Legionnaires' disease had been completed by an external company in May 2018, which had graded the service as 'low risk'. The assessment recommended that one director should complete Legionnaires' awareness training. During our inspection, we saw that this action had been completed. Legionnaires' disease is a serious pneumonia caused by the legionella bacteria. People become infected when they inhale water droplets from a contaminated water source such as water coolers and air conditioning systems.
- There had been no instances of healthcare acquired infections from January to December 2018.

**Environment and equipment**

- **The service had suitable premises and equipment and looked after them well. The environment promoted the privacy and dignity of women using the service.**
- The service facilities were located on the ground floor and were accessible to all women and visitors. The clinic rooms contained adjustable couches, which staff used to support women with limited mobility.
- The waiting room for the service had adequate seating, and there was a disabled toilet situated close to the clinic and waiting area with baby changing facilities.
- The environment in which the scans were performed was spacious, homely, and well arranged. Staff turned the lights off when undertaking a scan to darken the room, which meant scans could be observed clearly. Similarly, the sonographers locked the clinic room door during the ultrasound scans to promote the privacy and dignity of women.
- An external company completed the servicing of the ultrasound machine. The service record for the machine confirmed it had been serviced annually, the last completed in October 2018. Where faults arose outside of the planned services, staff called out engineers to assess and perform repairs.
- Electrical equipment was regularly serviced and safety tested to ensure it was safe for patient use. We reviewed five pieces of equipment, including a printer, lamp, and the ultrasound machine, and found all equipment had been serviced within the date indicated.
- Fire extinguishers were accessible, stored appropriately, and had all been serviced within the date indicated. Fire drills were held monthly, with the last completed in December 2018. No learning points had been identified during this drill.
- Waste was handled and disposed of in a way that kept people safe. Staff used the correct system to handle and sort clinical and non-clinical waste, the external clinical waste bin was secured and locked, and there was a service level agreement in place for its removal, when required.
- Sharp bins were clean, dated, not overfilled, and had temporary closures in place to prevent accidental spillage of sharps.
- There were arrangements in place for managing clinical specimens. A service level agreement was in place for the collection, processing, and reporting of blood samples. They were collected by a courier on the day they were taken and transferred to the external provider.

**Assessing and responding to patient risk**

- **The service had appropriate arrangements in place to assess and manage risks to women, their babies, and families.**
- The service accepted women who were physically well and could transfer themselves to a couch with little support. The service did not offer emergency tests or treatment.
- There were clear processes in place to guide staff on what actions to take if unexpected or significant findings were found on the ultrasound scan or following non-invasive prenatal testing (NIPT). If any concerns were identified, staff followed the service's

referral pathway and referred the woman to the most appropriate healthcare professional, with her consent. For example, if a woman received a 'high-risk' result following her NIPT, the directors referred the woman to the fetal medicine unit at the local NHS trust.

- From January 2017 to January 2018, staff made eight referrals to the local NHS trust, this included: five early pregnancy referrals, two referrals for 'high-risk' NIPT results, and one referral for an absence of a fetal heartbeat.
- Upon booking their appointment, women were advised to bring their NHS pregnancy records with them to their appointment at Preview Baby Limited. This meant the sonographers had access to women's obstetric and medical history, if required. It also meant that staff could contact the most relevant medical provider if a concern was detected.
- The sonographers frequently contacted each other for advice and support during their clinics. We were provided with one example where a sonographer came to the clinic during their non-working day to review an ultrasound scan for their concerned colleague.
- Staff advised women about the importance of still attending their NHS scans and appointments. The sonographers and phlebotomists made sure women understood that the ultrasound scans and screening tests they performed were in addition to the routine care they received as part of their maternity pathway. The terms and conditions for the service clearly explained this. Women were asked to sign a contract to confirm they had read and understood the terms and conditions before any service was undertaken.
- Due to the nature of the service provided, there was no emergency resuscitation trolley on site. However, staff had access to a first aid box. There was also clear guidance for staff to follow if a woman suddenly became unwell whilst attending the clinic. If staff had concerns about a woman's condition during their ultrasound scan, they stopped the scan and telephoned 999 for emergency support.
- All staff had completed first aid or basic life support (BLS) training, and would put their training to use until the ambulance arrived. BLS training gives staff a basic overview of how to deal with a patient who may have stopped breathing, such as starting cardiopulmonary resuscitation.
- Staff knew where the nearest automated external defibrillator (used to help resuscitate a patient in cardiac arrest) was in the town centre, which was publicly accessible.
- While staff did not formally use the 'Paused and Checked' checklist devised by the British Medical Ultrasound Society (BMUS) and Society of Radiographers, the sonographers told us they always completed the checks during their appointments. This included: confirming the woman's identity and consent; providing clear information and instructions, including the potential limitations of the ultrasound scan; following the BMUS safety guidelines; and informing the woman about the results.
- Scan reports were completed immediately after the scan had taken place, which we observed during our inspection.
- The service only used latex-free gloves and covers for the transvaginal ultrasound probe, which minimised the risk of an allergic reaction for women with a latex allergy.
- The service offered Group B Streptococcus (GBS) self-test kits to women between 35 and 37 weeks' gestation. While Preview Baby Limited was not involved in the processing or testing of the clinical specimens, they received a copy of the results. On receipt of the results, the service checked whether the woman's healthcare provider was aware of the results and had taken appropriate action, if the woman was found to be GBS positive.

**Staffing**

- **The service had enough staff with the right qualifications and experience to provide the right care and treatment.**
- Most staff were employed on a bank basis (as and when they were needed). This included the four sonographers and one phlebotomist/receptionist. A consultant obstetrician also worked at the service under practising privileges, and ran the fertility service. The granting of practising privileges is a

well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in an independent private practice, or within the provision of community services.

- All four sonographers were experienced radiographers, and all had previous obstetrics and gynaecology experience within the NHS trust. Similarly, the consultant obstetrician also worked at a local NHS trust.
- One of the directors of the service (the registered manager) was a registered midwife, and the other director was a qualified phlebotomist. They were responsible for the day-to-day running of the service, appointment bookings, staff rotas and managerial processes.
- The ultrasound clinics were scheduled in advance and the sonographers assigned themselves to the clinics, which fitted around their permanent employment positions.
- All staff we spoke with felt that staffing was managed appropriately. At all times, there were at least two staff in the clinic; this included a receptionist and a sonographer/doctor. No staff members were required to work as a 'lone worker'. Where staffing levels fell below this agreed threshold, all appointments would be rearranged. However, no appointments had been delayed for non-clinical reasons in the 12 months prior to our inspection.
- Preview Baby Limited did not use agency staff. In the event of a staff member going off sick, the sonographers and receptionists would cross-cover between themselves to help prevent clinic cancellations.
- From January to December 2018, there had been no staff sickness absences.
- There were no staff vacancies at the time of our inspection.

**Records**

- **Staff kept detailed records of women's appointments, referrals to NHS services and completed scan consent documents. Records were clear, up-to-date, and easily accessible to staff providing ultrasound scans.**
- During diagnostic ultrasound scans, the sonographer completed an electronic scan report during the woman's appointment. A printed copy of the scan report was given to the woman to take away with her. The service also stored the electronic-copy of the scan report, in case they needed to refer to the document in future.
- Where appropriate, and with consent, the sonographer would also send a copy of the scan report to the woman's GP or another relevant healthcare professional when a referral was made.
- The ultrasound images were stored on the ultrasound machine for six weeks before they were removed and archived on an external hard-drive.
- We reviewed four scan reports. Staff recorded all the specified information in a clear and accurate way. This included the woman's estimated due date, the type of ultrasound scan performed, the findings, conclusions, and recommendations.
- Staff stored completed consent records and blood sample forms securely in locked filing cabinets. Any electronic records or systems were password protected.
- Blood sample forms were checked by a colleague for completion before they were sent to the laboratory. This helped to prevent any delays due to inaccurate or incomplete forms. There was also a 'best practice' example of a completed blood sample form for staff to refer to.

**Medicines**

- The service did not store, prescribe, or administer any medicines.

**Incidents**

- **Processes were in place for staff to raise concerns and report incidents; however, staff had not needed to report any incidents within the last 12 months.**

Good

# Diagnostic imaging

- Staff reported any incidents directly to the directors in person, by telephone or email. The directors collated the incidents into an electronic log, which was used to identify any themes and learning. The directors were responsible for conducting investigations into all incidents.
- Although staff had not reported any incidents from January to December 2018, they could describe the process for reporting incidents and provided examples of when they would do this, such as a patient accident, if a woman became unwell or if a woman or partner became aggressive.
- Preview Baby Limited did not have any never events in the 12 months before our inspection. A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. The event has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.
- In accordance with the Serious Incident Framework 2015, the service did not report any serious incidents in the 12 months before our inspection.
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. The duty of candour regulation only applies to incidents where severe or moderate harm to a patient has occurred.
- Staff understood the duty of candour and the need for being open and honest with women and their families if errors occurred. The registered manager could explain the process they would undertake if they needed to implement the duty of candour following an incident, which met the requirements. However, at the time of our inspection, they had not needed to do this.
- The directors were aware of the requirements for reporting incidents to the CQC using the statutory notification route if this met the criteria, under Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

## Are diagnostic imaging services effective?

We do not rate effective.

**Evidence-based care and treatment**

- **Care and treatment provided was based on national legislation and good practice standards.**
- The service followed the 'ALARA' (as low as reasonably achievable) principles. This was in line with national guidance written by The Society and College of Radiographers (SCoR) and BMUS ('Guidelines for Professional Ultrasound Practice', (December 2018)). Where possible, the sonographers completed all ultrasound scans within 15 minutes to help reduce ultrasound patient dose.
- During the ultrasound scan, the sonographers monitored the thermal index and mechanical index to ensure they both remained within the recommended range for obstetric ultrasound. The sonographers also did not use colour doppler imaging (used to estimate the blood flow) during early pregnancy scans. This was in line with the BMUS and SCoR guidelines.
- Staff adhered to the 'Paused and Checked' checklist, which was designed as a ready reminder of the checks that need to be made when any ultrasound examination is undertaken. This was in line with national standards outlined by SCoR and BMUS.
- Local policies were in line with current legislation and national evidence-based guidance from professional organisations, such as the National Institute for Health and Care Excellence (NICE) and BMUS. The policies also contained links to further reading and helpful patient information. For example, one policy contained a link to printable patient information leaflets on the Public Health England's website. The leaflets explained the tests and treatment options available for the conditions screened for by the NHS fetal anomaly screening programme (FASP).

Good

# Diagnostic imaging

- Local policies did not contain a created or next renewal date. This meant we could not be assured that policies were reviewed in a timely manner. Following our inspection, the service immediately implemented a policy proforma, which outlined the creation and renewal date for each policy.
- There were protocols in place for the referral of women to other services if unexpected or significant findings were found during ultrasound scans or following non-invasive prenatal testing (NIPT). Staff ensured women understood that the services performed at Preview Baby Limited were in addition to those provided as part of their NHS pregnancy pathway and were not designed to replace any NHS care.
- The service was inclusive to all pregnant women and we saw no evidence of any discrimination, including on the grounds of age, disability, pregnancy and maternity status, race, religion or belief, and sexual orientation when making care and treatment decisions.

**Nutrition and hydration**

- To improve the quality of some ultrasound images, women 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 available on the service's website.
- Due to the nature of the service, food and drink was not routinely offered to women. However, there was a drinking water dispenser in the waiting area, which was accessible to women and visitors.

**Pain relief**

- Staff asked women if they were uncomfortable during their ultrasound scans, however, no formal pain level monitoring was undertaken as the procedures were pain free.

**Patient outcomes**

- **While staff monitored patient outcomes through their activity and patient feedback, peer review audits were not completed in line with national guidance. However, this was rectified immediately after our inspection.**
- At the time of our inspection, peer review audits were not undertaken in line with guidance issued by the British Medical Ultrasound Society (BMUS). This guidance recommends that peer review audits are completed using the ultrasound image and the written report. We raised this as a concern during our inspection, and it was immediately addressed by the directors. A rolling audit programme was introduced, which included peer review audits for each type of ultrasound scan performed. For example, in February 2019, the service planned to audit a sample of their growth and presentation scans, and in March 2019 they planned to audit their anomaly scans.
- The service monitored their referral rates. From January 2017 to January 2018, eight women were referred to their midwife or local NHS trust due to the detection of potential concerns or a high-risk non-invasive prenatal test (NIPT) result.
- Service activity, audit results and patient feedback were discussed during the monthly management meetings, and were fed-back to staff through their secure online social media group or informal staff meetings.

**Competent staff**

- **While the sonographer staff files did not contain evidence of appraisals or references, there were informal processes in place to assess sonographer competence and suitability for their role. Following our inspection, the directors reviewed and updated their current recruitment requirements.**
- As part of our inspection, we reviewed the staff personnel files for the directors, sonographers, consultant, and phlebotomist/receptionist. We found they all contained evidence of a recruitment and selection interview, employment history, and identification. However, two of the staff files did not contain evidence of disclosure and barring service (DBS) checks. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. We raised this as a concern during our inspection, and the directors provided evidence that the DBS checks had been completed.

Good

# Diagnostic imaging

- All the staff files did not contain evidence of employment references. This meant we could not be assured effective recruitment processes had been followed and staff were of good character. We raised this as a concern with the directors during our inspection, who told us that verbal references for staff had been sought from the lead sonographer at the local NHS trust. The lead sonographer also corroborated this.
- None of the personnel files contained evidence of appraisals, which had been completed by the staff's substantive employer. Appraisals provide evidence that individuals still hold the necessary skills and competencies to undertake their role safely and effectively. We raised this as a concern during our inspection, and we were told the directors regularly checked the professional registers for any indication of concerns. The lead sonographer also provided informal performance updates about staff to the directors, and the directors completed a formal review of staff after they had worked for the service for three months. All the staff personnel files we reviewed confirmed that staff had received a three-month review.
- Following our inspection, the directors reviewed their current recruitment requirements. We were provided with evidence which showed that references and appraisal copies had been requested from staff's substantive employers. In addition, a new checklist had been introduced for the front of the staff files to provide the directors' assurance that the files were complete.
- All four sonographers were registered with the Health and Care Professionals Council (HCPC) and the Society of Radiographers. They all had previous obstetrics and gynaecology experience within an NHS acute trust, and all still worked for the NHS.
- Similarly, the consultant obstetrician was registered with the General Medical Council, and the registered manager was registered with the Nursing and Midwifery Council. There was evidence of their professional registration in their personnel files.
- Each staff member completed a local induction, which included role-specific training. Newly employed sonographers worked closely with another sonographer for as long as they needed. This enabled the service to identify and address any competency issues with the individual before they worked alone.
- Additional training in the effective use of the ultrasound equipment had also been provided to the sonographers from the manufacturer of the ultrasound machine.
- The staff who were responsible for taking blood had all completed and passed venepuncture assessments with a local NHS hospital. While Preview Baby Limited did not complete formal competency assessments, the phlebotomists observed each other taking blood and would discuss their techniques and share best practice.
- The directors and the phlebotomist had jointly implemented a 'script' to follow when explaining the NIPT process to women. This ensured that women received consistent and accurate information, including the associated benefits and limitations of the NIPTs screening.

**Multidisciplinary working**

- **Staff of different disciplines worked together as a team to benefit women and their families.**
- During our inspection of Preview Baby Limited, staff described positive examples of the sonographers and receptionists working well together. Their professional working relationship promoted a relaxed environment for women and helped to put women and their families at ease.
- Although there had not been any formal staff meetings at the time of our inspection, staff reported that they were consulted about changes to service provision.
- The service had established pathways in place to refer women to their GP or local NHS trust if any concerns were identified during their appointment. Staff communicated their referral to the local NHS trust or GPs by telephone.
- Established working arrangements were also in place between the service and the blood laboratory who tested the NIPT specimens. Preview Baby Limited

tracked all samples sent to the laboratory to ensure results were received within five working days, as set out in their service level agreement with the laboratory.

**Seven-day services**

- **Preview Baby Limited did not provide emergency ultrasound scanning or tests. This meant services did not need to be delivered seven days a week to be effective.**
- The service did not open every day, but staff worked in a flexible way to meet the needs of women and their families. All scans performed were planned, with appointments arranged in advance.
- Clinics were generally held on Monday, Wednesday, and Friday evenings from 6 to 9pm, and every Saturday from 10am to 4pm. The fertility clinics were held every Tuesday and Thursday by appointment only.

**Consent and Mental Capacity Act**

- **Women were supported to make informed decisions about their care. Staff understood how and when to assess whether a woman had the capacity to make decisions about their chosen care. Staff were aware of the importance for gaining consent from women before conducting any ultrasound scan or screening service.**
- There were processes to ensure women consented to procedures. All women received written information to read and sign before their scan appointment, which was available in different languages. This information included terms and conditions, such as scan limitations, consent, prices and use of data. Staff checked the form was signed before a woman's appointment.
- Women's verbal consent was also sought before staff completing the ultrasound scan. The sonographers discussed the potential risks to the unborn child from additional use of ultrasound with the women. This enabled the women to make an informed decision on whether to proceed with the scan.
- Staff gave women the option of withdrawing their consent and stopping the ultrasound scan at any time.
- The service provided women with printed information about NIPT before they consented, this included information about the procedure and the potential results of the test. Staff also ensured that women were given enough time to ask any questions, and they fully understood how they would receive the results.
- Staff understood their roles and responsibilities under the Mental Capacity Act (2005). They knew how to support women who lacked the capacity to make decisions about their care.
- While staff had completed training in relation to the Mental Capacity Act (2005) as part of their mandatory training, they reported that they had not seen a woman who lacked capacity since the service opened in 2014.
- There was a consent and Mental Capacity Act (2005) policy for staff to follow, which clearly outlined the service's expectations and processes.

## Are diagnostic imaging services caring?

Good

We have not previously inspected this service. At this inspection, we rated caring as **good.**

**Compassionate care**

- **Staff cared for women with compassion. Feedback from women and their families confirmed that staff treated them well and with kindness. However, women were not made aware of the chaperone service available to them.**
- All staff were very passionate about their roles and were dedicated to making sure women received patient-centred care.
- Staff protected women's privacy and dignity. For intimate scans, the sonographers confirmed whether a woman was happy to have her partner, family or friends present. Staff offered to leave the room while the woman was undressing and the door was locked while the scan was undertaken. A sheet was provided for the woman to cover herself.

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- The waiting area was large, and music was played so women could speak to the receptionist without being overheard. One woman described staff speaking softly to ensure no one else knew what was being said.
- During our inspection we spoke with two women about their care. Feedback was positive. One told us she was offered a complimentary scan as she had visited so many times and described the service as "Brilliant from start to finish, I can't fault them".
- Women confirmed that staff introduced themselves at the start of the scan. They made sure they were comfortable and were reassured if they felt nervous.
- While a chaperone service was available, both women we spoke with were not aware of this option, and the service was not advertised in the patient waiting area. However, one of the sonographers told us that she always offered a chaperone to the women for intimate scans.
- The service gathered patient feedback through social media. All of the feedback was extremely positive, and included comments such as, "I was made to feel relaxed, welcome and nothing was too much trouble"; "They were really patient and allowed us to come back on multiple occasions because we could not see the baby's face due to her position"; "The welcome we received was lovely and the lady who did our scan was so kind. She explained everything she was doing".

**Emotional support**

- **Staff provided emotional support to women to minimise their distress.**
- Staff were aware that women attending the service were often feeling nervous and anxious so provided additional assurance and support to these women.
- If a woman received bad news, for example, a miscarriage, they could sit in the private phlebotomy room for as long as they needed, whilst being supported by a member of staff. Staff also allowed them to leave through the back entrance, or wait until the waiting room was empty if they did not want to walk through the reception area.
- Miscarriage support information and a miscarriage helpline was displayed in the clinic room. Staff also signposted women to local support groups in the event of a miscarriage or high-risk screening result.
- If a woman suffered a miscarriage prior to their appointment, staff refunded the woman's deposit payment as soon as they were informed.
- Scan results were given to the women at the time of their appointment. Contact numbers were on the scan reports for who to ring with any concerns or questions they had after the appointment.

**Understanding and involvement of patients and those close to them**

- **Staff involved women and those close to them in decisions about their care and treatment.**
- A personalised care policy was in place which stated, "Every woman, every pregnancy, every baby and every family is different, therefore quality services must be personalised". It described their aim to deliver an integrated approach to the care they deliver, and this was evident through our discussions with staff and women.
- Staff told us that before internal scans they spoke with the women privately to explain the procedure and what it involved. The women we spoke with confirmed that staff took the time to explain the procedure to them before and during the ultrasound scan. One social media review stated that staff had a, "professional and friendly approach, my questions were answered and you were very thorough, a wonderful clinic".
- Pricing was clearly displayed on the website. Staff drew women's attention to this.
- Up to four carers and representatives of the women were welcome to attend the appointments and staff ensured they were involved in the visit. A woman who visited with her disabled child described her sonographer: "she was totally amazing, explained all to my children and me". Another woman said, "so welcoming when all my family wanted to come join in on the experience too".
- Women were always given their scan results at the end of their appointment. The laboratory took five days to

return the blood results to the women, and women were kept updated if there were any delays. This was corroborated by one of the women who stated on social media feedback, "I had to return to have the test again, the service was great, phone calls to keep me updated and in the loop with all that went on".

## Are diagnostic imaging services responsive?

Good

We have not previously inspected this service. At this inspection, we rated responsive as **good.**

**Service delivery to meet the needs of local people**

- **The service planned and provided services in a way that met the needs of local people.**
- The facilities and premises were appropriate for the services delivered. The clinic was located on the ground floor of the building, and was accessible to all women and visitors.
- The clinic room had adequate seating available for those accompanying the women to their appointments. There was also one large wall-mounted slave monitor, which projected the images from the ultrasound machine. This enabled the women and their families to view the baby scan more easily.
- There was a large, comfortable waiting area where soothing music was played to create a relaxing and calming environment for the women and their families. It had pregnancy-related magazines and a water cooler for women and visitors to help themselves to. There was also a disabled toilet with baby changing facilities. If women wanted to breastfeed in private, staff facilitated this.
- While there were no toys for children, appointments were not often delayed so they were not kept waiting. Staff also involved children in the appointments as much as possible.
- There was free car parking on the road outside the clinic. Preview Baby Limited was also close to public car parks and transport links within the Home Counties and London.
- Ultrasound scans were available on Monday, Wednesday and Friday evenings, and all day on Saturdays. The fertility clinic was open on Tuesday and Thursday evenings. Clinic times had been determined by looking at trends and feedback from women.
- The service provided payment details in a confirmation email before the woman's appointment. Ultrasound scan prices were outlined on the service's website, and we observed staff clearly explaining costs and payment options to women when they phoned the clinic to make an appointment.
- The service offered women a range of baby keepsake and souvenir options, which could be purchased for a small fee at reception. This included; baby shower invites, pregnancy support and feeding pillows. The directors had consulted with women about what items the clinic should stock.
- Classes in hypnobirthing were provided to expectant couples at the service for an extra cost.
- Information about harmony testing and prenatal testing was accessible in the waiting room and Group B Streptococcus (GBS) self-test kits were available.
- A journal for women to capture questions, ideas, and memories throughout their pregnancy as well as their baby's firsts were available in the waiting area for women free of charge.

**Meeting people's individual needs**

- **The service took account of women's individual needs.**
- There was an equal opportunities policy, which stated that the service was "committed to the promotion of equal opportunities within our business, through the way we manage the organisation and provide services to the community". This demonstrated the service's aim to be inclusive to all pregnant women, and would not discriminate on the grounds of protected characteristics.
- On booking, the service asked women if they required any special assistance and staff ensured any requirements were met, where possible.
- The fertility clinic was held on different days to the pregnancy scanning service. This meant that women

who may be experiencing difficulties conceiving did not share the same waiting area with women who were pregnant, and meant the services were responsive to their needs.

- An external disability access audit was completed in August 2018. The audit looked at car parking, access to the service and its facilities, which were all graded as 'low risk' apart from the disabled toilet. The audit recommended that the service introduced grab rails and an emergency cord into the toilet. We saw that the grab rails were in place at the time of our inspection, but there was no emergency cord.
- There was an adjustable couch, which staff also used to support women with limited mobility.
- Although staff were not aware if a woman had a learning disability or mental health condition unless she disclosed it, the registered manager and sonographers had all completed Mental Capacity Act training and would ensure the woman understood what she was consenting to. The registered manager explained all women were treated equally, however staff would adapt to meet their individual care needs.
- The couch could accommodate women with a high Body Mass Index.
- The service used a telephone based interpretation service, which enabled staff to access a translator over the phone. Documents could also be uploaded to their website for translation, such as the service's terms and conditions disclaimer. Information leaflets about screening options could be printed from the Public Health England's website in different languages. Details on how to access these services was displayed in each clinic area for staff to follow.

**Access and flow**

- **Women could access the service when they needed it.**
- Women could book their appointments online, in person or over the phone. A non-refundable deposit was taken to secure the booking. However, if a woman suffered a miscarriage prior to their appointment, staff refunded the woman's deposit payment as soon as they were informed.
- There was no waiting list or backlog for appointments and last-minute bookings could usually be accommodated. We were provided with one example where a woman booked a same-day appointment.
- Appointments could be booked out of hours when the clinic was not open as all phone calls were transferred to the directors' mobile phones. This helped to reduce anxiety for women who had any concerns and wanted a scan appointment as soon as possible.
- Approximately 40 women per week were seen during the busiest periods. The clinic did not monitor rates of non-attendance; however, the directors reported that this had not been an issue because they took a small deposit payment from women at booking, and a text reminder was sent before the woman's appointment.
- From January 2017 to January 2018, the service made eight referrals to local NHS hospitals. This included five early pregnancy referrals, two referrals for high-risk results following non-invasive neonatal testing (NIPT) and one referral due to there being no foetal heartbeat visible on the scan.
- No clinics were cancelled or delayed in the 12 months prior to our inspection.
- Women were not kept waiting when they arrived and had the option to return if they had not been able to get a good photo from the scan due to the position of the baby.
- Waiting times for blood results were monitored by the service. The service level agreement with the blood laboratory confirmed that women should receive their results within five working days of their test. The directors monitored the waiting times through a proforma, which included the day the blood test was performed and the date the results were received from the laboratory. We reviewed this and found the five-day target was consistently met. Any concerns or delays were discussed with the laboratory.

**Learning from complaints and concerns**

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

Good

# Diagnostic imaging

- The service had a complaints' policy which included a practical guide for staff about how to handle verbal complaints. The policy also stated that complaints would be passed to a senior member of staff within 24 hours, should be acknowledged within three working days and resolved within 14 working days.
- There were no complaints received within the 12 months prior to our inspection. However, we were assured that they would be taken seriously, investigated appropriately and learning disseminated to the team. This would be done through informal discussions, through an encrypted social media messaging platform and at team meetings. There was a complaints log in place to record the woman's contact details, a description of the complaint, action taken and a resolution date.
- Staff checked that women were satisfied with the service they received before they left the clinic. Women could verbally feedback to staff, complete a feedback form available at reception or send an email. A copy of the complaint procedure was displayed at reception and explained in the disclaimer, which all women completed before their scan.

## Are diagnostic imaging services well-led?

Good

We have not previously inspected this service. At this inspection, we rated well-led as **good.**

### Leadership

- **The directors had the skills, experience, and integrity needed to run a sustainable service.**
- The managers had an awareness of the service's performance, limitations, and the challenges it faced. They were also aware of the actions needed to address those challenges.
- Staff knew the management arrangements and told us they felt well supported.
- All staff spoke overwhelmingly positively about the directors of Preview Baby Limited. They said the directors were friendly, approachable, and effective in their roles. Staff felt confident to discuss any concerns they had with them.

### Vision and strategy

- **Preview Baby Limited had a clear vision and strategy for what they wanted to achieve, with quality and sustainability as the top priorities.**
- The vision for the service was to: "Provide clients with exceptional prenatal care, support and information. We will use the latest technology, and care for our clients as individuals, with honesty, equality, and respect".
- While some of the staff we spoke with were unable to fully articulate the vision, it was evident they always worked within the ethos of it.
- As part of their business plan, the directors wanted to improve and expand their fertility clinic and services. They sought support from an external marketing company to help improve their online visibility and their social media marketing campaigns.
- The directors were also exploring the possibility of increasing their operational hours. However, they wanted to ensure the patient demand was there before doing this, and at the time of our inspection, they were actively monitoring this.

### Culture

- **The directors promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.** This was evident during our inspection.
- We spoke with four members of staff who all spoke positively about the culture of the service. Staff felt supported, respected, and valued, and all reported that they felt proud to work for Preview Baby Limited. There was a sense of ownership and pride in the service provided, and staff strived for excellence in the quality of service women received.
- The service operated an open and honest culture to encourage team working within the organisation. This was supported by the service's duty of candour policy.

Good

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- Any incidents or complaints raised would have a 'no blame' approach to the investigation. However, in circumstances where errors had been made, apologies would always be offered to the women, and staff would ensure steps were taken to rectify any errors. Staff were aware of the duty of candour regulation; however, they had not had any incidents which met the criteria where formal duty of candour had been required to be implemented.
- During and after our inspection, we informed the directors that there were areas of the service that required improvement. They responded positively to this feedback and immediately put actions in place, demonstrating an open culture of improvement.
- Action was taken to address behaviour that was inconsistent with the ethos of the service, regardless of seniority. The directors would follow the service's disciplinary policy, which stated that counselling or other good management practice would be used to resolve performance before any disciplinary action.

**Governance**

- **While most of the governance arrangements were clear and appropriate to the size of the service, there were not effective recruitment processes in place and peer review audits were not completed in line with national guidance. However, these concerns were addressed immediately after our inspection.**
- The directors had overall responsibility for clinical governance and quality monitoring. This included investigating incidents and responding to patient complaints.
- Management meetings were held monthly, and the meeting minutes demonstrated that complaints, incidents, patient feedback and service changes were discussed and reviewed. This information was cascaded to staff through the service-wide secure social media group and informal staff discussions. A team meeting had been scheduled for February 2019, where similar topics would be discussed.
- At the time of our inspection, there was not an audit programme in place to provide assurance of the quality and safety of the service. Peer review audits were not undertaken in line with guidance issued by the British Medical Ultrasound Society (BMUS). We raised this as a concern during our inspection, and a rolling audit programme was immediately introduced. This included peer review audits for each type of ultrasound scan performed at the service.
- At the time of our inspection, there was no formal arrangement in place to ensure the service was informed of any performance problems relating to a sonographer's practice as none of the personnel files contained evidence of appraisals. Similarly, none of the staff files contained evidence of employment references. This meant we could not be assured that Preview baby Limited had full oversight of the skills, suitability and capabilities of all staff working for their service. Following our inspection, the service's recruitment requirements were reviewed. The directors provided evidence which showed that staff references and appraisals had been requested and stored in their staff personnel files. In addition, a new checklist had been introduced for the front of the staff files to provide the directors' assurance that the files were complete.
- Preview Baby Limited did not require individual sonographers to hold their own indemnity insurance as they were covered under the service's insurance.

**Managing risks, issues, and performance**

- **The service had effective arrangements in place for identifying and recording risks. The risks and their mitigating actions were discussed with the wider team.**
- Given the small size of the service, the directors did hold a risk register; however, internal, and external risk assessments were completed for any identified risks. At the time of our inspection, three external risk assessments had been completed, which included health and safety, Legionnaires' disease, and fire. We saw that all risks had been graded as 'low risk', and any recommended actions had been implemented. For example, the health and safety risk assessment found that all portable appliances should be tested and tagged. At the time of our inspection, an annual electrical safety programme was in place.
- In addition, five internal risk assessments had been undertaken by the directors, including patient

accident, staff locking the building at the end of a clinic, and the sonographers' safety whilst in the scanning room. The risk assessments were reviewed every three months.

- Internal risk assessments were completed on a standard template to ensure consistent information was used. All templates had the risk identified, control measures, and the risk assessment review date.
- Most staff we spoke with could clearly articulate the main risks to the service, and what was being done to address them. The risk assessments were shared with staff when they were initially completed, and again if there were any changes or updates.
- There were appropriate policies in place regarding business continuity, which outlined clear actions staff needed to take in the event of extended power loss, a fire emergency, or other major incident.
- The service did not use formal key performance indicators to monitor performance. However, the service used patient feedback, complaints, and staff feedback to help identify any necessary improvements and ensure they provided an effective service.

**Managing information**

- **The service managed and used information to support its activities, using secure electronic systems with security safeguards.**
- The service was aware of the requirements of managing a woman's personal information in accordance with relevant legislation and regulations. General Data Protection Regulations (GDPR) had been reviewed to ensure the service was operating within them.
- Preview Baby Limited 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.
- Women's records and scan reports were easily accessible and were kept secure. Paper records were stored in locked filing cabinets, and all electronic records and systems were password protected.
- The directors told us they transferred all scan images onto an external hard-drive every six weeks and archived them. They then deleted the scan images from the ultrasound machine.

**Engagement**

- **The service engaged well with women, staff and the public to plan and manage appropriate services and collaborated with partner organisations effectively.**
- Women's views and experiences were gathered and used to improve service provision.
- While patient feedback forms were available for women to complete in the waiting area, the directors told us that very few women left feedback through this method. Instead, most women left feedback on the service's social media pages. For example, one woman commented; "Had a brilliant 4D scan, the clinic was clean, the lady who scanned me was lovely. It didn't feel rushed…would definitely recommend".
- The social media pages were monitored daily as staff recognised that this was women's preferred method of communication. All patient feedback, including comments left on social media, were discussed at the monthly management meetings.
- There was a website for members of the public to use. This held information regarding the services offered and the prices for each type of scan. There was also information about how women could provide feedback regarding their experience.
- Patient feedback was taken seriously and used to improve the service. For example, following feedback, the service amended their selection of pregnancy and baby souvenir products available for women to purchase.
- While team meetings were not held regularly due to staff availability, staff told us they felt actively engaged in service planning and development. An encrypted social media messaging platform was used to regularly update staff about service changes, share best practice and ask for staff feedback. At the time of our inspection, the next team meeting was scheduled for February 2019.

Good

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- Staff told us that the directors listened and implemented their suggestions about service provision. For example, the sonographers recommended that the service should stock sanitary towels for women who had experienced bleeding before, during or after their scan. In addition, the sonographers were also consulted about the layout of the scanning room, and had requested there to be both dimmable lighting and a lamp available.

**Learning, continuous improvement and innovation**

- **Staff could provide examples of improvements and changes made to processes based on patient feedback and staff suggestion.**
- The directors took immediate and effective actions to address some of the concerns we raised during the inspection. For example, they reviewed their recruitment procedures, requested copies of staff references and appraisals, and implemented a rolling audit programme.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider SHOULD take to improve

- The provider should ensure there are effective governance arrangements in place, so directors can assure themselves that staff are competent, of good character and suitable for their role.
- The provider should consider undertaking peer review audits of the ultrasound scans and reports in accordance with national guidance.
- The provider should review how women are made aware of the chaperone service, and how they can access it before their ultrasound scan appointment. The provider should also consider implementing a chaperone policy for staff to follow and provide chaperone training to any staff who may act as a chaperone.