Window to the Womb Aylesbury

Quality Report

Unit 12, Duck Farm Court
Station Way
West Aylesbury
HP20 2SQ
Tel: 01296 326114
Website: https://windowtothewomb.co.uk/studios/aylesbury-baby-scan-studio/

Date of inspection visit: 13 November 2019
Date of publication: 10/01/2020

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?	**Not sufficient evidence to rate**
Are services caring?	**Outstanding**
Are services responsive?	**Good**
Are services well-led?	**Good**

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

Summary of findings

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

Window to the Womb Aylesbury is operated by Baby Scan Clinic Ltd. and operates under a franchise agreement with Window to the Womb (Franchise) Ltd. The service provides diagnostic pregnancy ultrasound services to self-funding women across Buckinghamshire and wider.

The service provides diagnostic imaging for children over 16 years and adults. It is registered to provide the regulated activity of diagnostic and screening procedures. We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 13 November 2019.

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.

We rated it as **Good** overall.

We found good practice in relation to diagnostic imaging:

- The service had enough staff to care for service users and keep them safe. Staff had training in key skills, understood how to protect service users from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to service users, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment and managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of service users and had access to good information.
- Staff treated service users with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided exceptional emotional support to service users, families and carers.
- The service planned care to meet the needs of local people and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of service users receiving care. Staff were clear about their roles and accountabilities. The service engaged well with service users and the community to plan and manage services and all staff were committed to improving services continually.

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

Nigel Acheson
Chief Inspector of Hospitals (London and South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	**The service provided at this location was diagnostic and screening procedures. We rated this service as good overall because it was safe, caring, responsive and well-led.**

Summary of findings

Contents

Good

Window to the Womb Aylesbury

Services we looked at
Diagnostic imaging

Summary of this inspection

Background to Window to the Womb Aylesbury

Window to the Womb Aylesbury is operated by Baby Scan Clinic Ltd. As part of the agreement, the franchisor Window to the Womb Ltd provides the service with regular on-site support, access to their guidelines and policies, training and the use of their business model and brand.

Window to the Womb Aylesbury opened in October 2018 and provides diagnostic pregnancy ultrasound services to self-funding women, who are more than six weeks pregnant and aged 16 years and above. All ultrasound scans performed at Window to the Womb are in addition to those provided through the NHS.

We inspected this service using our comprehensive inspection methodology. We carried out a short notice announced inspection on 13 November 2019. We gave staff four working days' notice that we were coming to inspect to ensure the availability of the registered manager and clinics. The service has had a registered manager in post since October 2018 and was registered with the CQC to undertake the regulated activity of diagnostic and screening procedures.

We have not previously inspected this service

The service did not use or store any medications

Our inspection team

The team that inspected the service comprised a CQC lead inspector. The inspection team was overseen by Catherine Campbell Head of Hospital Inspection for South East Region.

Information about Window to the Womb Aylesbury

The service provides diagnostic imaging service (ultrasound scans) to self-funding pregnant women across Buckinghamshire and further. The service is run in a unit within a row of shops all on the same level. Window to the Womb was separated into two clinics: the 'Firstscan' clinic, which specialises in early pregnancy scans, and 'Window to the Womb' clinic which offers later pregnancy and wellbeing scans. The Firstscan clinic offers the following scans:

- Reassurance, viability, dating and specialist scans from six to 15+6 weeks gestation.

The Window to the Womb clinic offers the following scans:

- Wellbeing scans from 16 to 40 weeks' gestation.
- Wellbeing and gender scans from 16 to 23 weeks 'gestation.
- Growth and presentation scans from 26 to 42 weeks' gestation.
- 4D baby scans from 24 to 34 weeks' gestation.

All women accessing the service self-refer to the clinic and are all seen as private (self-funding) service users.

The service runs six clinics a week, Tuesday evenings, Wednesday during the day, Thursday and Friday evenings, all day Saturday and Sunday mornings.

During the inspection, we spoke with five staff including the registered manager, a sonographer, the franchise director and scan assistants. We spoke with two service users and four relatives. During our inspection, we reviewed 20 sets of service users records.

At the time of our inspection, Window to the Womb Aylesbury employed six scan assistants who were all on zero hours contracts. There were three sonographers, two full time and one part time who were on permanent contracts. The registered manager was the director of Baby Scan Clinic Ltd. A registered manager is a person who has registered with the Care Quality Commission

Summary of this inspection

(CQC) to manage a service. Like registered providers, they are 'registered persons. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how a service is managed.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the services first inspection since registration with CQC in 2018.

Activity (October 2018 to July 2019):

- Firstscan (6-15 week gestation) performed 917 scans.
- Window to the Womb (16-40 weeks gestation) performed a total of 904 scans.
- Total scans for the service were 1821.

Track record on safety for the period October 2018 to July 2019:

- No Clinical incidents.
- No serious injuries.

The service received three complaints.

Services provided under service level agreement:

- Clinical and or non-clinical waste removal .
- Interpreting services .
- Maintenance of medical equipment.
- Maintenance of fire extinguishers and smoke alarms.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated it as **Good** because:

We found the following areas of good practice:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect women and their families 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.
- The service controlled infection risk well. Staff used equipment and control measures to protect service users, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each service users and removed or minimised risks.
- The service had enough staff with the right qualifications, skills, training and experience to keep service users safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels.
- Staff kept detailed records of service users care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service managed service user safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave service users honest information and suitable support.

Are services effective?

Not sufficient evidence to rate

We do not rate effective for this type of service

- The service provided care and treatment generally based on national guidance and best practice. Managers checked to make sure staff followed guidance.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for service users.

Summary of this inspection

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- All staff worked together as a team to benefit service users. They supported each other to provide good care.
- Staff gave service users s practical support and advice to lead healthier lives.
- Staff supported service users s to make informed decisions about their care and treatment. They followed national guidance to gain service users s' consent.

Are services caring?

Outstanding 

We rated it outstanding because:

We found the following areas of good practice:

- Staff treated service users with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Feedback from people who used the service and those close to them was always very positive about the way staff treated people.
- Staff provided a strong visible person centred culture, providing emotional support to service users , families and carers to minimise their distress. They understood service users' personal, cultural and religious needs.
- Staff supported and involved service users, families and carers to understand their condition and make decisions about their care and treatment.

Are services responsive?

Good 

We rated it as **Good** because:

We found the following areas of good practice:

- The service planned and provided care in a way that met the needs of local people and the communities served.
- The service was inclusive and took account of service users individual needs and preferences. Staff made reasonable adjustments to help service users access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. The service did not have a waiting list.

Summary of this inspection

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included service users in the investigation of their complaint.

Are services well-led?

Good

Are services well-led?

We rated it as **Good** because:

We found the following areas of good practice:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for service users and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.
- Staff felt respected, supported and valued. They were focused on the needs of service users receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where service users, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and staff identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with service users, and the public to plan and manage services.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

However:

Summary of this inspection

- Staff told us they would look after children during scans, however the service had not performed a risk assessment around the safety of this practice.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Not rated	☆ Outstanding	Good	Good	Good
Overall	Good	Not rated	☆ Outstanding	Good	Good	Good

Notes

Good

Diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Outstanding
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Good

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 subjects included: infection prevention and control, fire safety, information governance, safeguarding adults and children, chaperoning, and the Mental Capacity Act 2005. This ensured all staff had information to care for people with a diverse range of needs.

The service had a mandatory training policy which detailed the expectations of mandatory training required for scan assistants and sonographers. We saw records that evidenced 100% of staff were up to date with their mandatory training.

The mandatory training was comprehensive and met the needs of the services users and staff. The service provided mandatory training on a rolling programme basis and staff accessed the training by e-learning modules or face to face sessions during their team meetings.

Managers monitored mandatory training and alerted staff when they needed to update their training.

The registered manager attended an external mandatory training course each year. The course covered topics such as: safeguarding adults and children training, basic life support, fire safety, information governance, complaints handling, conflict resolution, and moving and handling training.

Safeguarding

Staff understood how to protect women and their families 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.

There were clear safeguarding processes and procedures in place for safeguarding adults and children. All policies were available and easily accessible to staff.

Staff received training specific for their role on how to recognise and report abuse. Staff were familiar with the service's safeguarding policy and how to access it. They could tell us the procedure to follow if they had safeguarding concerns.

At the time of our inspection, 100% of staff were compliant with adult and children's safeguarding training. All staff we spoke with had received training in levels two for adult and children's safeguarding as appropriate. The registered manager was trained to level three and could access advice from the local council safeguarding teams if required. This met the intercollegiate guidance 'Safeguarding children and young people: roles and competences for health care staff' (January 2019).

Safeguarding policies and procedures were clear and staff we spoke with showed a comprehensive understanding of safeguarding issues for example

domestic violence and neglect. The children's safeguarding policy covered all aspects of children's safeguarding concerns including child sexual exploitation.

Staff were aware of their responsibilities if they identified a woman who had undergone female genital mutilation(FGM). Staff could describe the escalation process if they were to have safeguarding concerns and were aware of the policies and where to find them. The service had a separate FGM policy.

To safeguard people against experiencing the incorrect type of ultrasound scans we observed staff asking service users to confirm their identify and date of birth and the scan they were expecting to attend for. This evidenced staff followed best practice and used the British Medical Ultrasound Society's (BMUS) 'Have you paused and checked' checklist.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect service users, themselves and others from infection. They kept equipment and the premises visibly clean.

We observed well-presented staff who kept the equipment and premises visibly clean. They used control measures to prevent the spread of infection.

The service had a cleaning policy and checklist and we saw staff completed daily checks to ensure the facilities remained clean which included cleaning surfaces, the wipe clean toys and floors. We reviewed the checklists for the last three months and found they were complete.

Infection prevention and control standard operating procedures and policies were current and accessible for all staff.

The ultrasound room had washable flooring and wipe-clean furnishings. The service used fresh paper towelling on the couch for each service users.

We observed staff to use infection control procedures such as being bare below the elbow, having long hair tied up and using appropriate personal protective equipment such as gloves when completing the scan.

Staff took all linens to the launderette which who laundered them at 60 degrees. This followed appropriate washing guidelines to prevent cross infection.

Staff cleaned and safely stored equipment such as probes used for intimate ultrasound investigations (for example, trans vaginal investigations). Staff covered the probes during investigations and cleaned them with the recommended wipes post ultrasound scan. This eliminated the risk of cross infection between service users.

We saw hand sanitiser gel and soap placed by sinks and in prominent positions. We observed all staff washed their hands in accordance with the World Health Organisations five moments for hand hygiene technique both before and after service users care.

The registered manager completed hand hygiene audits and we saw evidence almost 100% of staff had complied with hand hygiene over the last three months. The registered manager documented actions required and the following month achieved 100% compliance.

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.

Window to the Womb Aylesbury was situated on the ground floor level of a group of retail units.

Service users arrived in the reception area which included comfortable seating and a water cooling machine. There was a print room for families to choose their photograph and video's, but this was also used for service users who had received bad news, the scanning room and a small office/storage room.

The couch in the scan room could accommodate women with a weight of up to 240 kg. This meant they were suitable for bariatric service users.

The service had purchased a brand new ultrasound machine on 28 November 2018. The registered manager reported its first annual service was due at the end of the month. Staff completed daily quality assurance checks for the ultrasound machine to ensure the equipment was safe to operate.

Fire extinguishers were accessible, stored appropriately, and were all up to date with their services. There were

suitable arrangements in place for fire safety, including a fire risk assessment and clear instructions for staff to follow in the event of a fire. Staff kept all fire exit doors clear of obstructions.

The service stored cleaning materials locked in cupboards within the store room in line with the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the legislation which requires employers to control substances which are hazardous to health. We saw risk assessment relating to the use of COSHH products which were up to date and reviewed regularly.

The service completed formal environmental risk assessments quarterly in areas such as water quality (legionnaire's disease) and health and safety risk assessments.

Staff handled waste and disposed of it in a way that kept people safe. Staff followed correct procedures to handle and sort different types of waste. The service had an agreement with a clinical waste removal company to remove clinical waste monthly.

Assessing and responding to service users' risk

Staff completed and updated risk assessments for each service users and removed or minimised risks.

Staff told us what action they would take if a service user became unwell or distressed while waiting for, or during, an ultrasound scan. The action taken depended on the specific situation and staff provided examples which showed they would take appropriate action.

Due to the nature of the service they did not require a resuscitation trolley, however, they did have a first aid box containing appropriate items and there was always someone on duty who had adult and children basic first aid qualifications. In the case of an emergency the service would call 999.

There were clear processes and pathways in place to guide the sonographer on what actions to take if the sonographer found unusual findings on the ultrasound scan. When asked, staff were clear on what these actions were. For example if a ectopic pregnancy was discovered (the baby was growing outside the womb) the pathway advised that the sonographer should call 999 for an ambulance.

The Window to the Womb Ltd franchise employed a full-time sonographer who was available to review real time scans if the sonographers needed a second opinion. Response times varied from 10-15 minutes to half an hour. Staff reported there was always a senior sonographer available for review during all clinics including clinics at weekends.

Upon booking their appointment, the service asked women to bring their NHS pregnancy records with them. This meant the sonographers with the service user's consent, had access to the obstetric and medical history. It also meant if there were any concerns staff could contact the relevant medical provider and GP.

Staff reported they had not had any incidences where a service user requested frequent scans, but they did advise scanning times were restricted to 10 -15 minutes as per the British Medical Ultrasound Societies (BMUS) guidelines.

The service followed the 'as low as reasonably achievable' (ALARA) principles, outlined in the 'Guidelines for Professional Ultrasound Practice 2017' by the Society and College of Radiographers (SCOR) and BMUS. This meant the ultrasound machine was set to the lowest levels to achieve the best picture.

We saw staff remind service users on the NHS maternity care pathway about the importance of still attending their NHS scans and appointments. Staff made sure they understood the ultrasound scans were in addition to the routine care they received as part of their NHS maternity pathway.

Scan assistants looked after children who accompanied service users to the scan in the waiting area if this was requested by the mother or there was a risk the mother had miscarried. However, the service had not completed risk assessments and while being responsive to the mother's requests, we were not assured the risks and how to mitigate them had been considered.

Sonographer and scan assistant staffing

The service had enough staff with the right qualifications, skills, training and experience to keep service users safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels.

Good

Diagnostic imaging

The service employed six scan assistants who were all on zero hour contracts. The service employed three sonographers on permanent contracts. Two worked full and one part time.

We saw evidence all sonographers who worked for the service were registered with the Health and Care Professions Council (HCPC) and the society of radiographers.

Scan assistants were responsible for staffing the reception desk, managing enquiries, appointment bookings, supporting the sonographers during the ultrasound scans, and helping the families print their scan images.

The service did not use bank or agency staff, since the sonographers and scan assistants could cover each other's sickness or leave between them and there were no staff vacancies at the time of inspection.

The service did not have a clinic manager and the registered manager took on the role as part of their day to day role which was effective for the everyday running of the clinic.

The registered manager communicated updates and shift cover requirements using an online application. All staff we spoke with reported this worked very well.

The service did not allow lone working and there were never less than three staff on duty which we observed at the time of inspection.

The service's staff sickness rate from October 2018 to September 2019 was zero.

Records

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

Service users' notes were comprehensive, and all staff could access them easily. The service securely stored records in locked filing cabinets in the office.

Service users having a Firstscan would receive a report written by the sonographer at the time of the scan to add to their NHS notes. For the later Window to the Womb scans service users received a pre-printed foetal wellbeing report which detailed the baby's position, gender (if requested), foetal anomaly sweep, a check of the brain amniotic fluid, lungs and heart, abdomen and limbs, growth and placental position. The service stored a copy of the information in case they needed to refer to the document in future.

Where appropriate, and with consent, the sonographer would also send a paper copy of the scan report to the service users GP or another relevant healthcare professionals when making a referral.

Staff saved the ultrasound images onto a memory stick, which they uploaded to Window to The Womb's 'mobile phone application ('app'), which was a free password access only application for service users. The app enabled instant access to scan images and any video recordings made. Once staff uploaded the images they deleted the images from the memory stick.

We reviewed 20 records including referral forms from the Firstscan and Window to The Womb clinics. Staff recorded information in a clear and accurate way. This included the service users estimated due date, the type of ultrasound scan performed, the findings, conclusions, and recommendations as well as the service users consent to the scan.

Managers reviewed records as part of an audit process by both the registered manager and during the franchisor's yearly audit. Managers raised any issues directly with the individual sonographers.

The service had an up-to-date information governance policy in place for staff to refer to. The policy detailed staff responsibilities, documentation standards, and the retention of records. The policy was in line with Article 5 (e) of the General Data Protection Regulation (GDPR) states personal data shall be kept for no longer than is necessary for the purposes for which it is being processed.

All computers and the ultrasound machine were password protected and we observed staff locked them when not in use which ensured there was no unauthorised access to service users reports and details.

Medicines

The service did not store or administer medicines

Incidents

Good

Diagnostic imaging

The service managed service user safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave service users honest information and suitable support.

The service used a paper-based incident reporting system and had an accident book available in the clinic for staff to access. The registered manager was responsible for handling investigations into all incidents. The registered manager used the incidents log to identify any themes and learning and shared with staff through the electronic app and monthly staff meetings.

Staff we spoke with knew how to report incidents and could give examples of when they would do this. The registered manager was responsible for investigating incidents and would share lessons learned with the whole team. When things went wrong, staff apologised and gave service users honest information and suitable support.

From October 2018 to the date of inspection there were two incidents documented which was an attempted break in and the requirement to call the police.

The registered manager was aware of the requirements for reporting incidents and sending notifications to the CQC. At the time of inspection, the registered manager had submitted one notification.

Staff we spoke with fully understood the duty of candour. Providers of healthcare services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Duty of candour training was part of the staffs' mandatory training requirements.

Are diagnostic imaging services effective?

Not sufficient evidence to rate

We do not rate effective for this type of service.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

The registered manager checked to make sure staff followed guidance. Staff had to sign and date a checklist to confirm they had read policies as part of their induction and when the service updated policies. We saw evidence of these completed checklists.

We reviewed 16 local policies which were version controlled and current and included a next review date. This ensured the serviced reviewed the policies regularly. If relevant policies referenced national guidance.

The clinical lead, a diagnostic sonographer and clinical nurse specialist from the franchise wrote the policies, and the lead sonographer and a consultant in obstetrics and gynaecology reviewed them. They followed national guidance from the Royal College and Society of Radiographers, the foetal abnormality screening programme (FASP) standards and British Medical Ultrasound Society (BMUS). For example, the service did not offer transvaginal scans to women over 10 weeks gestation in line with BMUS guidance.

The service followed as low as reasonably achievable (ALARA) principles outlined by the Society and College of Radiographers. Sonographers did not scan for longer than 10 to 15 minutes and would not repeat scans within seven days of the earlier scan, which reduced any risks that prolonged scans may cause to the unborn baby.

The service had an audit programme to assure itself of the quality and safety of the clinic. The franchisor completed annual sonographer competency assessments and an annual clinic audit. The registered manager completed monthly and quarterly clinic audits. Included in this audit were the signed terms and conditions to ensure staff had requested all service users read and signed the conditions.

Good

Diagnostic imaging

Upon request from the clinical lead the registered manager would send a random selection of ultrasound videos for review. This assured the service the scans were continually of a good standard.

The franchisor (Window to the Womb Ltd) employed a consultant radiographer to advise the board on compliance with national standards and ensure policies and strategy were in line with best evidence-based practice.

Nutrition and hydration

Staff gave service users appropriate information on drinking water before a scan to ensure they attended with a full bladder which enabled the sonographer to gain a better view of the unborn baby.

A water fountain was available in the reception area for service users.

Pain Relief

Staff did not formally check pain levels as the procedure was pain free. However, we saw that staff asked service users if they were comfortable during their scan.

Patient Outcomes

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

The service monitored service users' outcomes and experience through their monthly clinic audits and service user's satisfaction feedback cards. Managers and staff used the results to improve service users' outcomes.

The franchisor (Window to the Womb Ltd) carried out an annual compliance audit and we saw the service was compliant with all aspects of the audit. The audit showed areas of improvement for the sonographers and what actions to take. For example, the clinical lead requested the registered manager forwarded six further specific scans for review over the next three to four months for assurance the issues raised were resolved.

We saw that compliance with audits was a standing agenda item and discussed at monthly team meetings. Staff discussed feedback from women and local performance during team meetings.

For the period October 2018 to September 2019 the service had referred 90 service users to a local NHS trust due to the detection of potential concerns. The service contacted each referred service user the day after to check on their wellbeing and as a way of ensuring the sonographers referred appropriately.

The service used key performance indicators to monitor performance, which the franchisor set. The service benchmarked themselves against the other clinics in the group for number of reviews received, number of rescans and number of completed scans.

The franchise monitored the accuracy rate of gender confirmation scans. The franchise reported the accuracy rate to be 99.9% accurate. If it was not possible to identify gender because of the baby's position, for example, the service offered service users a free rescan.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were qualified, experienced, and had the right skills and knowledge to meet the needs of service users, and managers gave all new staff a full induction tailored to their role before they started work. We saw evidence of the induction checklist which included for example, mandatory training, an introduction to the first scan service and the future for the service.

None of the staff at the service had been in post for more than one year which meant they had not yet received an appraisal. However, we saw the appraisal process was in place and all staff we spoke with were aware of the process.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The registered manager printed out all team meeting minutes and placed them in a folder.

The sonographers had an annual competency assessment from the lead sonographer for Window to the Womb Ltd. As part of the assessment the lead sonographer checked the sonographers' registration,

indemnity insurance and revalidation status. We saw evidence the franchisor's sonographer completed annual reviews of sonographers within Window to the Womb Aylesbury.

All sonographers were registered with the Health and Care Professional's Council (HCPC) and on the voluntary register with the Society of Radiographers.

Sonographer to sonographer peer reviews took place in line with The British Medical Ultrasound Society (BMUS) recommendations, we reviewed a sample of the peer review audits and found the sonographers had raised no concerns with each other's reporting.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff reported they had the opportunity to discuss training needs with their line manager and the registered manager support staff to develop their skills and knowledge.

The registered manager attended update meetings with the franchisors twice a year which included mandatory training sessions.

Multidisciplinary working

All staff worked together as a team to benefit service users. They supported each other to provide good care.

During the inspection we saw the team worked well together and observed positive communication between the scan assistants, sonographer and registered manager.

The service had liaised with local NHS trusts to ensure their referral pathways were effective and appropriate. For example, one NHS trust had requested the service ask all women who the sonographer had identified as not being pregnant to have a pregnancy test before attending the early pregnancy unit. This ensured women were receiving appropriate onward referrals.

The service ensured where service users had consented for the service to share their information, GP's received a copy of the ultrasound report and onward referral by post or electronically.

Seven-day services

The service was not open seven days a week however, the service ran six clinics a week. These clinics took place on Tuesday evenings, Wednesday during the day, Thursday and Friday Evenings, Saturday all day and Sunday mornings.

The service ran clinic sessions designed to accommodate the needs of service users and their families. For example, evening and weekend appointments enabled working mothers, their partners and siblings to attend.

Health promotion

Staff gave service users practical support and advice to lead healthier lives.

The service provided families with a wide range of information leaflets about pregnancy specific issues or concerns, for example morning sickness, complications in pregnancy and information for mums to be.

Consent and Mental Capacity Act

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and they knew who to contact for advice.

We saw evidence all staff had completed the online Mental Capacity Act 2005 training.

Staff gained consent from service users for their care and treatment in line with legislation and guidance. Staff reported there had never been an incident where a service user attended who lacked the capacity to consent. However, all staff we spoke with were able to tell us the actions required to take if a service user was unable to consent.

All staff were aware of the importance of gaining consent from service users before conducting an ultrasound scan. The scan assistants explained the procedure and service users had the opportunity to withdraw if they wished. The sonographer confirmed names and spellings and dates of birth prior to the scan and obtained verbal consent to begin.

Good

Diagnostic imaging

All service users received written information to read and sign before their scan. This included a technology and safety briefing, terms and conditions, information on scan limitations, a crib sheet on what was included in the scan package, information on medical records, consent and use of data.

The pre-scan questionnaire and declaration form included a self-declaration stating the woman was receiving appropriate pregnancy care and consent to share information with the NHS. We saw clear signed consent in 10 pre-scan questionnaires and foetal wellbeing reports we reviewed.

We spoke with two service users and their families who said they had all consented for their scan and understood the procedure and any potential risks.

Staff understood Gillick Competence. (Gillick Competencies is used in medical law to decide whether a child under 16 can consent to his or her own medical treatment, without the need for parental permission or knowledge). They followed a consent policy which included Gillick competence guidelines to ensure young people could understand what they were consenting for and were able to make decisions. Staff were also clear they would observe safeguarding children guidelines in all these cases.

Are diagnostic imaging services caring?

Outstanding ☆

We rated it as **outstanding.**

Compassionate care

Staff treated service users with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Feedback from people who used the service and those close to them was always very positive about the way staff treated people.

Staff were highly motivated discreet and responsive when caring for service users. Staff were inspired by the registered manager and took time to interact with service users, and those close to them in a respectful and considerate way. We noted staff were concerned women received a good experience more than the up sale element of the business.

We observed staff treating service users with dignity, kindness, compassion, courtesy and respect before during and after their scans. During our inspection we observed two scans, two consent and payment procedures and two discharges. Staff remained professional throughout and ensured that the service user and their families understood the next steps.

The service gave 15 to 30-minute timeslots for appointments. Staff told us this was to ensure the privacy and dignity of the service users and their family was maintained and to allow more time if bad news was delivered.

All conversations took place in a private room. If a scan was not successful or unable to determine the gender the service offered a free second scan.

During our inspection, we spoke to two service users and their companions. All service users and companions we spoke with during our inspection described the service positively. For example, one service user reported her experience was “overwhelming but in a very good way, it was nice to have the complete scanned explained to us in a way we could understand”

Another service user described the service as “ Thank you for everything you have done for us and looking after us, you are all amazing”

The service received consistently positive praise. Service users we spoke with said they appreciated the extra time for the appointment and the service’s friendly, caring approach.

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

The registered manager ensured staff treated service users with respect and dignity. For example, the provider knew the names of the service users arriving and had checked any previous obstetric history they already had on file. During the scan, they offered service users paper towels and a gown to wear to protect their dignity.

Good

Diagnostic imaging

During our inspection we spoke with two service users and their families, and all described the service positively. For example, service users commented the booking process was easy, the appointment times were flexible and accommodating, and they were well informed before, during and after the appointment.

All service users we spoke with would be happy to recommend the clinic to their friends and family.

Staff asked service users to complete feedback forms after their scans. We reviewed over 25 feedback forms and all rated the service as five out of five.

Emotional support

Staff provided a strong visible person centred culture, providing emotional support to service users, families and carers to minimise their distress. They understood service users' personal, cultural and religious needs.

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. Staff were full committed to working in partnership with the service users to ensure they are active partners in their care.

The service separated clinics into two categories: the Firstscan clinic, which specialised in early pregnancy scans; and the Window to the Womb clinic, which offered later pregnancy scans. This ensured service users who were at risk of miscarriage did not mix with other service users later in their pregnancy. The service was careful what was displayed on the screens in the reception area to ensure they were sensitive for the Firstscan customers.

There were high levels of emotional support available to service users and their families. Scan assistants acted as chaperones and had received chaperone training, to ensure service users felt comfortable and received excellent emotional support.

During our inspection we observed two appointments. Throughout these appointments the sonographer described what they saw and explained findings in a way the service user and their families could understand. For example, we saw the sonographer measuring each part of the baby and clarifying their findings for reassurance.

Staff told us they gave service users as much time as they required if they became distressed and would make time to allow the service user and their family to ask questions.

The service would arrange follow up appointments with the service users' midwife or hospital if needed. Staff respected the service user's privacy and dignity by keeping them in the scan room and completing all documentation before leaving the room or alternatively would move them to the print room which could be used as a quiet room.

The registered manager ensured staff received training on the emotional aspects of receiving bad news. We saw this documented in staff files. The service gave service users information on counselling services should they have needed them.

Service users we spoke with at inspection reported they had received detailed explanations of scan procedures and accompanying written feedback. Staff told us they informed service users when they needed to seek further advice and support. Staff told us they always ensured their service user knew how to access other agencies for support before leaving the clinic and we observed this during inspection.

Service users we spoke with during our inspection told us they felt reassured by the information they received before their appointment and that it helped them prepare for their scan.

We reviewed very positive written feedback from service users who had received difficult news and had been referred to NHS antenatal care providers. For example, one service user reported "Staff were so kind and empathetic and really did allow us to take our time. The staff explained fully what had happened and what the scan finding meant. You have the most incredible staff".

We saw evidence all staff had received training in equality and diversity and diversity was one of Window to the Womb's values.

The franchisor also offered a confidential line to staff should they wish to discuss anything that has affected them.

Understanding and involvement of service users and those close to them

Good

Diagnostic imaging

Staff supported and involved service users, families and carers to understand their condition and make decisions about their care and treatment.

During our inspection we saw service users and their families treated with kindness and respect by staff. Staff welcomed service users and their families including children to the service and there was enough room to accommodate eight guests with the service user in the clinic room. This may help children to bond with their unborn sibling.

Staff took time to explain the procedure before and during the scan. We saw the sonographer fully explain what was going to happen throughout the scan. They used appropriate language to explain the position of the unborn baby and the images on the monitors. They asked service users if they had any questions throughout and at the end of the scan.

Before the scan, staff asked service users if they wanted to know the gender of the baby. If they didn't, they advised them they would ask them to look away from the screen when the baby's genital area was scanned. By warning them in advance, this avoided any anxiety or surprises.

For Firstscan appointments the two viewing screens in the scan room remained off until the sonographer had found a heartbeat. If the sonographer could not locate a heartbeat, they would ask the service users if they would like to view the scan which enabled the service user and their family to feel empowered in the decision making process.

When service users arrived in the clinic, scan assistants reviewed the prices of the scans with the service users to ensure they had booked the correct scan for their requirements and were aware of the charges.

Service users and their families were able to leave feedback on open social media platforms, which the registered manager monitored. We reviewed a selection of reviews and found the service was very highly rated, and feedback was overwhelmingly positive. Recent reviews on one online review service rated the service five out of five from 65 reviews.

The service had received hundreds of written compliments from October 2018 to September 2019. All were very positive and would recommend the service to friends and family.

The franchisor had developed a smart device application which allowed service users to securely view their scan images and videos remotely. The application enabled women to share their images and video to social media sites, or other individuals, as they so wished.

Are diagnostic imaging services responsive?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

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

The facilities and premises met the needs of service users, including their children. The large waiting area had children's toys, seating and books. The clinic was located close to public transport links and provided free parking. The service provided information on travelling to the clinic on their website. The clinic was accessible for wheelchair users.

The toilets were situated outside of the unit but were easily accessible for wheelchair users.

The scanning room could comfortably accommodate up to eight people and included a scanning couch, privacy screen, comfortable seating and two large screens for service users to view the images. The couch in the scanning room was able to accommodate weights of 250kg which meant they were suitable for service users. Bariatric service users were advised it may be slightly more difficult to obtain good images before the start of the scan.

The service had developed a mobile phone application. The application enabled service users to document and share week-by-week images of their pregnancy 'bump' with their family and friends and create a time-lapse

video of their pregnancy journey. Scan assistants saved any scan image taken during a Window to the Womb appointment onto the application. This enabled service users to have instant access to their scan images.

The service saw only self-funding service users. They did not see any NHS service users. The service had a range of packages with different price options which it clearly displayed on the website and in the reception area. Service users could book appointments online or over the phone. The service offered out of hours appointment times, in the evenings and during weekends

Staff discussed the ultrasound packages with the service users upon entering the clinic to ensure the package met their needs. All packages included a wellbeing scan.

The service users we spoke with said the clinic was easy to find, and provided a calm, professional environment.

Meeting people's individual needs

The service was inclusive and took account of service users individual needs and preferences. Staff made reasonable adjustments to help service users access services. They coordinated care with other services and providers.

The service could accommodate service users in wheelchairs for an ultrasound scan as staff could control the examination couches electronically to enable the service user to transfer to the couch safely (as long as the service user could safely transfer themselves).

Service users received written information to read and sign prior to their scan appointment. The franchise had recently introduced an online translation service where written information was translated into many different languages for all scans. There was also the ability for the computer to read the scan information aloud for service users with visual impairments.

The ultrasound scan room provided a calm and relaxing atmosphere with dimmed lighting to ensure the service users were able to view the scan picture on the screens clearly.

Staff were able to extend and change clinics to support service users. For example, the service would often accommodate a service user who required reassurance for a last minute scan on the same day.

Staff gave information leaflets to service users when they had a pregnancy of an unknown location, for example, an ectopic pregnancy, a second scan that confirmed a complete miscarriage or an inconclusive scan. The leaflets contained a description of what the sonographer had found, advice, and the next steps they should take.

Staff gave Firstscan service users an NHS contacts sheet detailing the local NHS early pregnancy units, when they were open, telephone numbers and the most appropriate service to access within the various NHS trusts.

All service users we spoke with reported their appointment times were long enough for them to ask questions and gain reassurance. It also allowed time for the service user to go for a walk to encourage the foetus to move to improve the scan image.

Access and flow

People could access the service when they needed it and received the right care promptly. The service did not have a waiting list.

From October 2018 to July 2019 the service had not cancelled any scans.

The service did not have a waiting list for appointments. Service users could self-refer to the service on the same day if required. Service users could book their scans through the website, via telephone or email.

Staff managed the reception and telephone lines whilst the building was open, which meant there was someone available to answer questions and book appointments for most of the weekdays, evenings and Saturdays.

The sonographer gave the results of the ultrasound scans to the service user immediately after the scan which enabled them to discuss their results with the relevant health care professional in a timely manner.

On the day of inspection, we saw service users arrive in the reception area and wait no longer than five minutes for their scan. Scan assistants advised service users to arrive 10 minutes early for their scan to ensure time to complete the paperwork and to discuss the scan procedure.

Good

Diagnostic imaging

The booking system was flexible and allowed changes to packages to meet service users' choices. Service users paid a small deposit upon booking the scan and could change the package when they attended for their scan appointment if they wished.

If a service user did not attend for their appointment the service would not follow up due to the risk the service user may have miscarried. However, if a service user contacted the service to say they had miscarried the service would offer a full refund of all deposits paid.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included service users in the investigation of their complaint.

Managers investigated complaints and identified themes. The service had received three complaints between October 2018 and July 2019. The service did not uphold any of the complaints which meant the service was not at fault.

Window to the Womb had a policy for managing complaints which was current, and version controlled. It included timescales for acknowledging a complaint (three days) and responding within 21 days. We reviewed three complaint responses and found the registered manager had responded to these complaints within the three and 21 working day rule. All three complainants received a written response to their complaint which offered an apology.

The complaints policy referred to external bodies such as the Independent Sector Complaints Adjudication Service. These are independent bodies that can make final decisions on complaints that have been investigated by the provider and have not been resolved to the complainant's satisfaction. This ensured service users with complaints had the correct information of where to escalate complaints if they were not satisfied with the services' response.

Staff understood the policy on complaints and knew how to handle them. Staff described how they managed a complaint and preferred to hear about any issues early so they could deal with the concern promptly. To do this, the registered manager encouraged staff to ask if service users were happy with the service before they left the clinic.

We saw information for service users was available within the reception areas, leaflets and website on how to make a complaint.

We saw evidence and staff told us managers shared feedback from complaints and compliments with staff either individually or as a group during staff meetings and feedback used to improve the service.

Staff described learning from complaint where the service user believed they were past 16 weeks gestation and had booked a gender scan. When scanned the sonographer felt they were at least two weeks behind and was therefore unable to perform the gender scan. As a result, the service now requests all gender scan customers to bring in their NHS notes which confirms their actual gestation.

All service users and their families we spoke with during inspection were aware of how to make a complaint but saw no reasons to complain and could not suggest any improvements the service could make.

Are diagnostic imaging services well-led?

Good

We rated it as **good.**

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for service users and staff. They supported staff to develop their skills and take on more senior roles.

The registered manager owned Baby Scan Clinic Ltd with another family member and owned the Window to the Womb Aylesbury franchise. The registered manager took responsibility for all aspects of the service, including governance, clinical management, health and safety and quality.

Good

Diagnostic imaging

As part of the agreement, the franchisor Window to the Womb Ltd provided Baby Scan Clinic Ltd. with regular on-site support, access to their guidelines and policies, training and the use of their business model and brand.

The registered manager oversaw the sonographers, scan assistants and was responsible for the everyday running of the clinic. The registered manager shared business information with the directors of the franchise Window to the Womb Ltd. We observed clear management and reporting arrangements in place.

The registered manager attended six monthly national franchise meetings organised by Window to the Womb Ltd. During these formal meetings there was an opportunity to network and share best practice ideas as well as receive ongoing training and have discussions around clinic compliance, performance, audit, and best practice. We observed positive working relationships between the registered manager and the Window to the Womb Ltd franchise director.

The registered manager was always available via telephone if there were any service user or staff concerns which meant staff were always able to contact the registered manager for advice or in the event of an adverse incident.

Staff told us the registered manager was accessible and approachable if they wanted advice or to make suggestions. The registered manager kept staff informed of any developments for the service.

Staff could access support, advice and guidance from three clinical leads employed by Window to the Womb Ltd. This included a consultant radiographer and specialist nurse in early pregnancy. The clinical lead for Window to the Womb Ltd assessed all new sonographers and had over 35 years NHS sonography experience. The specialist nurse in early pregnancy provided clinical leadership regarding Firstscan early pregnancy scans and completed an annual check of the clinic.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

The registered manager was able to identify areas of development for the service and had a strategy in place to meet these requirements. For example, to increase scanning appointments to meet demand the service would need more staff.

The service had also identified values, which underpinned their vision. Their values included: Focus, dignity, integrity, privacy, diversity, safety and staff. All staff we spoke with were aware of the values and embedded them into every day practice. Staff told us their purpose was to provide a positive customer experience.

There were also aims, which identified what the service needed to do to achieve their vision. Examples included: “to provide pregnant ladies with medically relevant ultrasound findings by way of an obstetric report”, and “to report any suspected abnormalities identified using the pathways we have established with our local NHS hospitals”.

Culture

Staff felt respected, supported and valued. They were focused on the needs of service users receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where service users, their families and staff could raise concerns without fear.

The franchise had a freedom to raise a concern guardian, a freedom to speak out policy and a whistleblowing policy which staff were aware of. Staff told us they could make comments and suggestions, could talk freely and felt supported to drive improvements by the registered manager

Staff told us they worked well together as a team and there was an open and honest culture. We saw a ‘no blame’ approach to the investigation of complaints and the registered manager addressed performance issues through open and honest one to one feedback with staff.

All staff spoke proudly about their roles within the service and staff felt supported in their work. Staff told us they felt valued and supported by colleagues and the registered manager.

Good

Diagnostic imaging

There was a strong emphasis on the care of the women and their families. Staff promoted openness and honesty and understood how to apply the duty of candour. All staff were aware of what the term duty of candour meant.

The franchisor offered a confidential counselling service to staff should they wish to discuss any events or issues that had affected them. Staff we spoke with were aware of this service.

Throughout our inspection, the registered manager responded positively to feedback. They told us of improvements they had introduced immediately following feedback from inspections at other Window to the Womb locations. This demonstrated a culture of openness and willingness to learn and improve.

The registered manager told us if they recognised a strength in a staff member they would encourage growth and development to move them up to a more senior role. For example, the registered manager had identified a scan assistant with leadership potential and was encouraging them to take on more of the registered managers role.

Governance

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

The service had a clear governance process to continually improve the quality of service provided to service users. Staff understood their roles and responsibilities in relation to governance. The franchisor provided a governance structure for Window to the Womb clinics, which the Aylesbury clinic followed. The franchisor held meetings with the registered manager to monitor compliance with governance processes and the registered manager fed back learning at team meetings and daily operational meetings.

Window to the Womb Ltd had a clear governance policy which outlined the responsibility of board members, the relationship between franchisor and franchisee and the requirement for regular audits.

The service improved service quality through regular audits and clinical reviews by lead clinicians employed by Window to the Womb (Franchise) Ltd. Governance arrangements were clear and appropriate to the size of the service. However, the service did not audit the service users waiting times for staff to call them through. This would help identify any areas for service improvement.

Window to the Womb Ltd had indemnity and medical liability insurance which covered all staff working within the service for the case of a legal claim and was in date.

Baby Scan Clinic Limited followed a robust recruitment process for all staff, which included references and Disclosure and Barring Service checks. We saw evidence the registered manager had undertaken all recruitment checks correctly. Window to the Womb Ltd conducted due diligence checks on all franchisees in line with its fit and proper persons policy.

Staff told us they had monthly team meetings where all staff would attend. The minutes were available to all staff on line and printed out. If staff could not attend a meeting the registered manager asked them to sign a printed version of the minutes to confirm they had read them.

While the service did not hold formal governance meetings, items discussed at team meetings included risks, complaints and incidents as well as mandatory training update sessions and general updates regarding the business's overall performance.

Staff were clear about their roles, what managers expected of them and for what and to whom they were accountable.

Managing risks, issues and performance

Leaders and staff identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The registered manager had an awareness of the service's performance and challenges. They could describe actions to address these challenges. For example, the challenge of finding and keeping good staff which resulted in a high quality service.

The service did not have a risk register however, we saw evidence the registered manager reviewed all risk assessments monthly to ensure they documented any

changes or identified new risks. However, the risk of children cared for by scan assistants whilst their mother was in the scan room had not been risk assessed and not detailed in the risk assessments.

We saw up-to-date and complete risk assessments for fire, health and safety, legionnaires' disease and the Control of Substances Hazardous to Health (COSHH). The registered manager recorded risk assessments on a form which identified the risk and control measures and the member of staff responsible for monitoring and managing the risk. We saw risk assessments were easily accessible to all staff and all staff had seen them.

To mitigate the risks of lone working, there were always at least three staff on site when the service was open.

The service used key performance indicators (KPIs) to monitor performance, which the franchisor set. This enabled the service to benchmark themselves against the 36 other franchised clinics. We saw evidence the clinic was performing well against the other franchises.

The service had a documented business continuity plan, and undertook monthly fire alarm drills to ensure staff were aware of the process to take in the case of an emergency

The audit program undertaken by the registered manager helped them to identify any risks to the provision of a quality service rating to performance and adherence with policies and guidance.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

Window to the Womb Ltd was registered with the Information Commissioner's Office (ICO), 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.

Service users consented for the service to store their records. This was part of their signed agreement within the form detailing the ultrasound process. This demonstrated the service's compliance with the General Data Protection Regulation (GDPR) (2018).

The service had an up to date privacy notice policy which referred to all relevant legislation regarding staff responsibilities, documentation standards and the retention of records.

Staff could see how many scans the service had completed and how many service users' sonographers had referred to maternity services for ongoing care. The service recorded each referred service user and reported back to the franchisor. Staff could view the numbers monthly.

There was enough information technology equipment for staff to work with across the service. This meant staff had access to the required information at the time they needed it.

The service had not experienced any information breaches.

Engagement

Leaders and staff actively and openly engaged with service users, and the public to plan and manage services.

The service asked service users to fill in a comment card whilst they were waiting for their scan prints. There were also opportunities for service users and their families to leave comments on social media pages and online review sites.

The service had an easily accessible website where service users and their families were able to leave feedback and contact the service. This showed service users were able to engage with the service online and verbally. The franchisor and the registered manager reviewed all feedback methods to identify areas for improvement.

The registered manager shared customer feedback at the monthly team meeting and the team agreed any actions for improvement.

Good

Diagnostic imaging

Staff reported the registered manager would consistently seek feedback from all staff members with regards to improving the safety and quality of the service and all staff felt their ideas were listened to.

The service had increased the number of early pregnancy scan appointments to reflect demand. The service now provided more weekday evening appointments for both early pregnancy and 16 weeks plus to suit demand.

The registered manager encouraged staff to think creatively about ways to raise money for charities. Each month staff would nominate a charity to raise money for.

Window to the Womb Ltd produced a six-weekly newsletter called 'open window'. Open Window contained information on what was happening across the franchise and updates on e-learning and policies. We saw all staff signed to say they had read the newsletter and the service kept copies in a communication folder.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Staff took pride in their work and aimed to make improvements where possible. The registered manager said they shared learning from the sonographers working in the NHS trusts and found this useful.

The service had acted to address some of the concerns raised after other inspections in the franchise. This included ensuring staff were completing the newly introduced Mental Capacity Act (2005) training.

The registered manager identified a gap in the market for mindfulness in pregnant women. With an external provider they developed a mindfulness card set specifically for women who were pregnant.

Outstanding practice and areas for improvement

Outstanding practice

The service demonstrated a commitment to ensuring service users expectations were exceeded. Feedback from several sources was overwhelmingly positive.

The needs of women who may be experiencing loss were considered, with clinics running at different times depending on the stage of pregnancy. A quiet room was also available, and staff were able to spend as much time with the service user as needed.

Areas for improvement

Action the provider SHOULD take to improve

The service should ensure risk assessments are completed and any risk mitigated for scan assistants caring for service users children outside of the scanning room.