Window To The Womb

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

Window To The Womb in Watford is owned by New Beginnings South 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 Hertfordshire, Bedfordshire, and Buckinghamshire.

We inspected this service using our comprehensive inspection methodology. We carried out a short-notice announced inspection on 8 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:

- The facilities and premises met the needs of the range of people who accessed the service. This included children who accompanied women to their scans. The service also recognised that women's preferred method of communication had changed, and as a result, they had developed a range of innovative products to tailor their services and meet the needs of local people.
- The service took a proactive approach to understand women's individual needs, and delivered care in a way that met these needs, which was accessible and promoted equality.
- Women could access services and appointments in a way and at a time that suited them. Technology was used innovatively to ensure women had timely access to treatment.
- The service treated concerns and complaints extremely seriously. The registered manager completed comprehensive investigations, which frequently involved input from other professionals, such as the lead sonographer. Lessons learned were shared with all staff.
- Staff were caring, kind and engaged well with women and their families.
- Managers 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.
- Window To The Womb 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. Managers also did not have full oversight of what training the sonographers had completed at their substantive employer. However, these concerns were addressed immediately after our inspection.

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 Window To The Womb. 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, technology was used innovatively to ensure women had timely access to treatment, and the registered manager 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 managers did not have full oversight of what training the sonographers had completed at their substantive employer. This was addressed immediately after our inspection.

Summary of findings

Contents

Good

Window To The Womb

Services we looked at
Diagnostic imaging.

Summary of this inspection

Background to Window To The Womb

Window To The Womb is a private diagnostic service based in Watford, Hertfordshire. It is owned by New Beginnings South Ltd, and operates under a franchise agreement with Window To The Womb (Franchise) Ltd. Window to the Womb (Franchise) Ltd was established in 2003 and now has 36 franchised clinics across the United Kingdom.

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 in Watford opened in 2014 and provides diagnostic pregnancy ultrasound services to self-funding women, who are more than six weeks' gestation and aged 18 years and above. All ultrasound scans performed at Window To The Womb 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 2014.

We have not previously inspected this service.

Our inspection team

The inspection team was comprised of two CQC inspectors. The inspection team was overseen by Kim Handel, Inspection Manager, and Bernadette Hanney, Head of Hospital Inspection.

Information about Window To The Womb

The service provides diagnostic imaging services (ultrasound scans) to self-funding pregnant women across Hertfordshire, Bedfordshire, and Buckinghamshire. It is located on the first floor of a medical centre, which has ramp and lift access.

Window To The Womb has separated their services into two clinics: the 'Firstscan' clinic, which specialises in early pregnancy scans; and the 'Window to the Womb' clinic, which offers later pregnancy scans.

The Firstscan clinic sees approximately 30 women per week and offers the following scans:

- Viability scans from six to 10+6 weeks' gestation.
- Dating scans from eight to 12+6 weeks' gestation.
- Reassurance scans from 12 to 15+6 weeks' gestation.

The window to the womb clinic sees between 65 to 75 women per week and offers the following scans:

- Wellbeing scans from 16 to 40 weeks' gestation.
- Wellbeing and gender scans from 16 to 22 weeks' gestation.
- Growth and presentation scans from 26 to 42 weeks' gestation.
- 4D baby scans from 24 to 34 weeks' gestation.

They do not offer nuchal translucency scans or the 20-week anomaly scans. This is because these diagnostic tests are offered as part of the current NHS pregnancy pathway. They also do not offer non-invasive prenatal tests (NIPT).

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

The service runs six clinics per week. Standard operational hours are Monday and Tuesday mornings, Wednesday and Thursday evenings, Friday afternoon and evening, and all-day Saturday and Sunday.

At the time of our inspection, Window To The Womb employed a registered manager who owned the service,

Summary of this inspection

and five scan assistants on zero-hour contracts. Four sonographers worked out of the service on a self-employed basis. The service did not use controlled drugs (CDs).

During our inspection, we visited the registered location in Watford, Hertfordshire. We spoke with five staff members, including the registered manager, sonographer, scan assistants, and the franchise director. We also observed seven ultrasound scans, spoke with four women and their partners, and reviewed 10 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:

- Window To The Womb performed a total of 5,617 ultrasound scans from January to December 2018. A breakdown of the type of scan can be seen below:
- 1,569 (28%) early pregnancy scans, including; 1,034 viability scans, 340 dating scans and 195 reassurance scans.
- 4,048 (72%) later pregnancy scans, including: 2,124 4D baby scans, 1,634 gender scans, 180 wellbeing scans and 110 growth and presentation scans
- All women were self-funding.
- For the reporting period of January to December 2018, Window To The Womb did not cancel any patient appointments for non-clinical reasons.
- For the reporting period of January to December 2018, no procedures 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 recorded two incidents from January to December 2018.
- The service reported zero serious injuries from December 2017 to November 2018.
- The service received eight complaints from January to December 2018.
- Window To The Womb received hundreds of written compliments from January to December 2018.
- Window To The Womb 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

- **The service provided mandatory training courses in key skills to scan assistants and the registered manager. However, there was no oversight on what training the sonographers had completed at their substantive employer; this was rectified after our inspection.**
- The sonographers who worked for Window To The Womb on a self-employed basis, completed their mandatory training at their substantive NHS employment. However, the service did not have oversight on what training these individuals had completed or when. We raised this as a concern to the registered manager and the franchise director. Following our inspection, we were provided with evidence that the sonographers' mandatory training matrix had been requested and stored in their staff personnel files. The managers had also shared this learning with the other franchised clinics across the UK.
- The registered manager ensured that any sonographer who did not work within the NHS, accessed and completed the mandatory training provided by Window To The Womb.
- Scan assistants completed their mandatory training on a rolling training programme. Training courses were provided through 'e-learning' modules or 'face-to-face' sessions at their team meetings. They covered key areas, such as: equality and diversity, fire safety awareness, consent and mental capacity, infection prevention and control, safeguarding adults, and safeguarding children training.
- At the time of this inspection, all five scan assistants (100%) were compliant with their required training modules.
- The registered manager attended an external mandatory training course each year. The course covered important 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 the need to protect people from abuse, and had completed safeguarding training at the required level to ensure they had the appropriate knowledge to do so.**
- At the time of our inspection, 100% of the scan assistants were compliant with safeguarding adults training level two, which was the level appropriate to their role.
- Although Window To The womb 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 four of the five scan assistants had received safeguarding children's training level two, and one of the scan assistants had received

safeguarding children's training level three. This met the intercollegiate guidance 'Safeguarding children and young people: roles and competences for health care staff' (March 2014).

- The sonographers did not receive safeguarding training from Window To The Womb as they completed this training at their substantive NHS employer. At the time of our inspection, the service did not have a copy of their training certificates, which meant we could not be assured the sonographers had completed training at the required level. Following our inspection, the registered manager provided evidence which showed that all the sonographers had completed both level two adults' and children training. This meant the safeguarding training was in accordance with national legislation.

- < >he registered manager ensured that any sonographer who did not work within the NHS, accessed and completed the safeguarding training provided by Window To The Womb.

  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 adults and children's level three safeguarding training.

- Staff we spoke with had not made any safeguarding referrals; however, they were able to confidently tell us how they would identify a safeguarding issue and what action they would take. This included informing the safeguarding lead for the service.

- There were up-to-date safeguarding adults and children's policies for staff to follow, which included the contact details of the local safeguarding boards. There was also a copy of the local authority's 'Safeguarding children, young people, and adults at risk' policy, which reflected relevant national legislation and local requirements.

- A separate female genital mutilation (FGM) policy provided staff with clear guidance on how to identify and report FGM. Staff we spoke with were aware of the Department of Health's 'Female genital mutilation and safeguarding guidance for professionals' (March 2016). If staff were concerned about any woman, they would refer to the local safeguarding team.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff kept themselves, the equipment, and the premises clean.** The clinic room, toilets, reception and waiting areas were visibly clean and clutter free on the day of our inspection.

- Window To The Womb had infection prevention and control (IPC) policies and procedures in place, which provided staff with guidance on appropriate IPC practice.

- Cleaning was recorded on daily and weekly check sheets, which were reviewed by the registered manager. We reviewed the cleaning checklists and saw cleaning had been consistently completed. The standards of cleanliness were also monitored throughout the day by staff. For example, the scan assistants checked the toilets, studio floor (when raining), and reception area every hour to confirm they were clean and tidy.

- 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 day. We observed staff cleaning equipment and machines during our inspection.

- Staff used paper towel to cover the examination couch during the scanning procedure. We observed staff changing the towel at the end of the woman's appointment.

- Women were given a towel to use during their ultrasound scan to help maintain their dignity. Following their appointment, the used towels were placed in a laundry bin, and were laundered at a minimum temperature of 60 degrees.

- A supply of personal protective equipment (PPE) was available and accessible to all staff. Staff used the PPE appropriately when interacting with women, and all had their 'arms bare below the elbows' in clinical areas (to help prevent the transfer of infection from clothing that could be contaminated, and allow staff to wash their hands thoroughly).

- Staff washed their hands using the correct hand hygiene techniques before, during and after patient

contact. Handwashing basins and sanitiser gels were available in the clinic room and toilets. Hand sanitiser was also available for staff, women, and visitors to use at the reception desk.

- At the time of our inspection, hand hygiene audits were not undertaken to measure staff compliance with the World Health Organisation's (WHO) 'Five Moments for Hand Hygiene'. These guidelines are for all staff working in healthcare environments and define the key moments when staff should perform hand hygiene to reduce the risk of cross contamination between patients. We raised this as a concern during our inspection, and were told that the service would introduce hand hygiene audits immediately. Following our inspection, the registered manager sent us a copy of their newly developed hand wash audit proforma.
- A risk assessment for Legionnaires' disease had been completed in September 2018 against the water dispenser in the reception area. The assessment identified actions the service was taking to mitigate the risk, including biannual servicing and sanitisation of the dispenser. 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 first floor of a medical centre and were accessible to all women. There was ramp and lift access to the building, and the clinic room contained an adjustable couch, which staff used to support women with limited mobility.
- The waiting room for the service had adequate seating, and there were two toilets situated close to the clinic and waiting area, including a disabled toilet with baby changing facilities.
- The environment in which the scans were performed was spacious, homely, and well arranged. Staff turned the lights off and pulled down the black-out blinds when undertaking a scan to darken the room, which meant scans could be observed clearly. This also promoted the privacy and dignity of women. Similarly, the scan assistants locked the clinic room door and provided a dignity screen for women to get changed behind before their transvaginal scans.
- Blue mood lighting and soothing music was played during the scan appointments to create a relaxing and calming environment for the woman and her family.
- The clinic room had adequate seating available for those accompanying the women to their appointments. There were also two wall-mounted monitors, which projected the images from the ultrasound machine. This enabled the women and their families to view the baby scan more easily.
- 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 August 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 printers, computers, 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 every six months, with the last completed in December 2018.
- Substances which met the 'Control of Substances Hazardous to Health Regulations' (COSHH) (Health and Safety Executive, 2002), were stored in a locked cupboard in the staff room. There was clear signage on the cupboard door to alert staff to its contents. The cupboard also contained the service's most recent COSHH risk assessment and policy.
- Waste was handled and disposed of according to best practice. Staff used the correct system to handle and sort clinical and non-clinical waste, and there was a service level agreement in place for its removal.

Assessing and responding to patient risk

Good

Diagnostic imaging

- **The service had appropriate arrangements in place to assess and manage risks to women, their babies, and families.**
- There were clear processes in place to guide staff on what actions to take if any suspicious findings were found on the ultrasound scan. If they had concerns, the sonographer followed the service's referral pathway and referred the woman to the most appropriate healthcare professional, with her consent. For example, if the sonographer detected polyhydramnios (too much amniotic fluid), they would refer the woman to the fetal medicine unit or the antenatal clinic at the local NHS trust. If the sonographer suspected placental abruption (where the placenta separates early from the uterus) or an ectopic pregnancy, they immediately dialled 999 for emergency assistance.
- Staff documented referrals on dedicated referral forms, which were reviewed by the registered manager and input onto an electronic log.
- During our inspection, we reviewed four referral forms. All contained a description of the scan findings, the reason for referral, who the receiving healthcare professional was and what action they were going to take. For example, a sonographer made a referral to an early pregnancy unit as they identified no fetal heartbeat during the ultrasound scan. The early pregnancy unit informed the scan assistant that they would contact the woman immediately and arrange for them to come in and have another scan to confirm the findings.
- Upon booking their appointment, women were advised to bring their NHS pregnancy records with them to their appointment at Window To The Womb. 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 could contact a lead sonographer for advice and support during their clinics. The lead sonographer was employed by the franchisor and was available to review any ultrasound scan remotely within one to two hours.
- Staff advised women about the importance of still attending their NHS scans and appointments. The sonographers made sure women understood that the ultrasound scans they performed were in addition to the routine care they received as part of their maternity pathway.
- 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.
- 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.
- Both the scan assistants and the registered manager 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.
- The service used the 'Paused and Checked' checklist devised by the British Medical Ultrasound Society (BMUS) and Society of Radiographers, which was displayed in the clinic room and helped to remind staff to carry out checks. Although it was not formally documented, we observed the sonographer completing the checks during appointments, which 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 covers for the transvaginal ultrasound probe, which minimised the risk of an allergic reaction for women with a latex allergy.

Staffing

Good

Diagnostic imaging

- **The service had enough staff with the right qualifications and experience to provide the right care and treatment.**
- There were five scan assistants employed on zero-hour contracts. They were responsible for managing enquiries, appointment bookings, supporting the sonographers during the ultrasound scans and helping the families print their scan images. One of the scan assistants had recently been promoted to a team leader, and was responsible for the day-to-day running of the service in the absence of the registered manager.
- Sonographers were not directly employed, however, four sonographers worked for the service on a self-employed basis. The sonographers were all experienced radiographers, doctors, or midwives, and all had previous obstetrics and gynaecology experience.
- 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 three staff in the clinic; this included two scan assistants and a sonographer. No staff members were required to work as a 'lone worker'. Where staffing levels fell below this agreed threshold, all appointments would be rearranged.
- Window To The Womb did not use agency staff. In the event of a staff member going off sick, the scan assistants and sonographers would cross-cover between themselves to help prevent clinic cancellations. In circumstances where this was not possible, the registered manager covered the scan assistant role. This helped to prevent clinic cancellations.
- The registered manager monitored staff sickness rates. From January to December 2018, there had been no staff sickness absences.
- Information provided by the service indicated that one scan assistant had left the service within the last 12 months. However, one scan assistant and one sonographer had joined the service within the last year.

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.**
- The sonographer undertaking the ultrasound scan completed the paper scan report during the woman's appointment with the support of the scan assistant. A copy of the scan report was given to the woman to take away with her. The service also stored a paper-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 paper copy of the scan report to the woman's GP or another relevant healthcare professional when a referral was made.
- The ultrasound images were saved onto a USB stick, which could be purchased by the woman at the end of her appointment. The woman was also given free access to the a mobile phone application ('app'), which had been developed by the franchisor. The app enabled women to have instant access to their scan images.
- We reviewed ten scan reports from both the Firstscan and Window to The Womb clinics. 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.
- 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 service kept completed service user records securely. The consent records and referral forms were archived and stored securely on site. Staff kept

completed records in locked filing cabinets. Any electronic records or systems were password protected, and the passwords were changed every time a staff member left the service.

Medicines

- The service did not use any controlled drugs or medicines for any of their procedures.

Incidents

- **Processes were in place for staff to raise concerns and report incidents. Staff understood their roles and responsibilities to raise concerns and record safety incidents. Lessons learned were shared with the whole team and the wider service.**
- The service used a paper-based reporting system, and the accident and incident book was available in the clinic for staff to access, if required. The registered manager was responsible for conducting investigations into all incidents. They collated the incidents into an electronic log, which was used to identify any themes and learning, and was shared with staff at their team meetings. The registered manager also submitted a monthly incident return to the franchisor.
- All staff we spoke with described the process for reporting incidents and provided examples of when they would do this, such as information governance breaches or equipment breakdown. The process for incident reporting and investigating was outlined in the service's incident reporting policy.
- From January to December 2018, the service had reported two incidents, which related to concerns with the air-conditioning unit and the building's carpark. We saw that these incidents received an appropriate review by the service, and action was taken to minimise the risk of recurrence. For example, all air-conditioning units within the clinic were reserviced.
- Window To The Womb 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 registered manager was 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

- **The service used current evidence-based guidance and good practice standards to inform the delivery of care and treatment.**
- Local policies and protocols were in line with current legislation and national evidence-based guidance from professional organisations, such as the National Institute for Health and Care Excellence (NICE) and the

British Medical Ultrasound Society (BMUS). The policies also contained links to further reading. For example, the service's fetal abnormality policy referenced the NHS fetal anomaly screening programme as additional reading.

- Staff demonstrated a good understanding of national legislation that affected their practice. For example, sonographers followed the 'Ectopic pregnancy and miscarriage: diagnosis and initial management' guidance (NICE, 2012) when they identified a fetus did not have a visible heartbeat and measured less than 7.0mm.
- In addition, the service followed the ALARA (as low as reasonably achievable) principles, outlined in the 'Guidelines for professional ultrasound practice, 2017' by the Society and College of Radiographers (SCoR) and BMUS. Where possible, sonographers completed all ultrasound scans within 10 minutes to help reduce ultrasound patient dose.
- All policies and protocols contained a next renewal date, which ensured they were reviewed in a timely manner.
- Staff were aware of how to access policies, which were stored electronically on an internal computer drive. Paper copies were also accessible to staff.
- Staff ensured women understood that the ultrasound scans performed at Window To The Womb were in addition to those provided as part of their NHS pregnancy pathway and were not designed to replace any NHS care.
- We observed a sonographer providing clear information to women about their ultrasound scans, including the potential limitations of the scan. Similarly, staff verbally signposted women to NHS services if they experienced symptoms, such as vaginal bleeding or pain at the end of their scanning appointment.
- There was an audit programme in place to provide assurance of the quality and safety of the service. Peer review audits were undertaken in accordance with recommendations made by the British Medical Ultrasound Society, and the franchisor completed annual sonographer competency assessments. Other audits, such as clinic and local compliance audits were undertaken regularly. They monitored patient experience, cleanliness, health and safety, ultrasound scan reports, equipment, and policies and procedures. For example, audit results for the audit completed in September 2018 indicated that the service needed to remove their fire extinguishers directly from the floor, and re-do the fire risk assessment. We found that all the required actions had been completed at the time of our inspection.
- 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 the ultrasound image, women were asked to drink an extra two glasses of water per day on the lead up to their appointment, and to have a snack a couple of hours before their scan. Women who were having a gender scan were encouraged to attend their appointment with a full bladder. This information was given to women when they contacted the clinic to book their appointment. It was also included in the 'frequently asked questions' on the service's website.
- 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. There was also a fridge containing soft drinks and confectionary, which could be purchased by the women and their families for a small fee.

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

- **Staff monitored the effectiveness of care and treatment and used the findings to improve their practice.** The service monitored patient outcomes through their activity, annual patient satisfaction survey and clinical audits.
- The service used key performance indicators (KPIs) to monitor performance, which were set by the franchisor. This enabled the service to benchmark themselves against the 35 other franchised clinics. At the time of our inspection, the registered manager reported that they were in the top five performing clinics for both their later and early pregnancy services.
- Service data was also collected and reported to the franchisor every month to monitor performance. This included information about the number of ultrasound scans completed including the number of rescans, and the number of referrals made to other healthcare services.
- From September to December 2018, the later pregnancy clinic completed 125 re-scans, which was 9% of the total number of scans completed. Most of the rescans were completed because it was not possible for the sonographer to confirm the gender of the baby at the time of the appointment. For the same period, the Firstscan clinic did not complete any rescans.
- From January to December 2018, the service referred 85 women to their GP, midwife, or the local NHS trust due to the detection of potential concerns.
- The service reported a 99.9% accuracy rate for their gender confirmation scans. This figure was based on over 20,000 gender scans completed at the 36 franchised clinics across the UK. There was a breakdown figure for the individual clinics. There was a rescan guarantee in place for when it was not possible for the sonographer to confirm the gender of the baby at the time of the appointment. If the woman received incorrect information with regards to their baby's gender, they were offered a complimentary 4D baby scan. The sonographer involved also received additional support from the lead sonographer, who was employed by the franchisor.
- Window To The Womb had recently introduced sonographer peer review audits. The sonographers reviewed each other's work and determined whether they agreed with their ultrasound observations and report quality. This was in line with BMUS guidance, which recommends peer review audits are completed using the ultrasound image and written report. At the time of our inspection, seven peer review audits had been completed since November 2018. We reviewed a sample of the peer review audits and found that no concerns were identified.
- Service activity, audit results and patient feedback were regularly discussed during the monthly team meetings.

Competent staff

- **Staff had the skills, knowledge and experience to deliver effective care and treatment. While the sonographer staff files did not contain evidence of appraisals or references, there were processes in place to assess sonographer competence and suitability for their role.**
- As part of our inspection, we reviewed the staff personnel files for the registered manager, sonographers, and scan assistants. We found they all contained evidence of a recruitment and selection interview, employment history, identification, employment contract, and disclosure and barring service (DBS) checks. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.
- The sonographer 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 registered manager and the director of the franchise during our inspection.
- Similarly, none of the four sonographer personnel files contained evidence of appraisals, which had been completed by their substantive employer. Appraisals provide evidence that individuals still hold the necessary skills and competencies to undertake their role safely and effectively. There was no formal arrangement in place to ensure Window To The Womb was informed of any performance problems or other concerns relating to a sonographer's practice. We

raised this as a concern during our inspection, and we were told the registered manager regularly checked the professional register for any indication of concerns. In addition, the lead sonographer completed initial (when the sonographers first joined the service) and annual competency assessments. As part of these assessments, the lead sonographer checked the sonographers' registration, indemnity insurance and revalidation status. If any concerns were identified, the registered manager was expected to address them immediately, and additional training or further observation was provided to the sonographer. The staff files we reviewed confirmed that all four sonographers had received a competency assessment within the last 12 months.

- Following our inspection, the registered manager and director reviewed their current recruitment requirements. We were provided with evidence which showed that references and appraisal copies had been requested from the sonographers' substantive employers. The recruitment policy was also amended to reflect the staff file changes.
- All four sonographers were registered with the Health and Care Professionals Council (HCPC), the Society of Radiographers, the General Medical Council or the Nursing and Midwifery Council. There was evidence of their professional registration in their personnel files. Most of the sonographers had previous obstetrics and gynaecology experience within an NHS acute trust, and three of the four sonographers still worked for the NHS.
- Each staff member completed a local induction, which included mandatory and role-specific training. Staff accessed their role-specific training through the service's electronic training portal. Training records confirmed that all staff had completed their appropriate role-specific training.
- Window To The Womb also provided 'in-house' training videos to the sonographers, which were developed by the franchisor. The videos covered obstetric and fetal anomalies, including ectopic pregnancy, triploid syndrome (a condition where a fetus has three copies of every chromosome instead of the normal two) and anencephaly (a condition where the brain or spinal cord of a fetus does not develop properly). The sonographers also had workbooks to complete once they had watched the videos.
- Throughout the year, the scan assistants assessed the sonographers for their quality of customer care and service, standard of communication, and overall customer experience. The sonographers received verbal and written feedback, and the registered manager ensured any identified learning points were implemented by the sonographers immediately. At the time of our inspection, five customer care and service audits had been completed since October 2018.
- The service manager was responsible for appraising the scan assistants. Appraisals were completed on an annual basis and once completed, were stored in staff files. Information provided by the service showed there was a 100% appraisal compliance rate for all scan assistants that had been employed for more than 12 months.

Multidisciplinary working

- **Staff of different disciplines worked together as a team to benefit women and their families.**
- During our inspection of Window To The Womb, we observed positive examples of the sonographer and scan assistants 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 were no formal meetings between the registered manager and the sonographers, they had regular informal catch-up sessions, and the sonographers 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 letter and telephone. The service used a printed referral template and hand wrote the woman's details and the reason for referral, and attached a copy of the scan report and images.

Seven-day services

Good

Diagnostic imaging

- **Although Window To The Womb was not an acute service and did not offer emergency tests or treatment, it still operated seven days a week and worked in a flexible way to accommodate the needs of the women.**
- Clinics were generally held on a Monday morning; Tuesday morning; Wednesday evening; Thursday evening; Friday afternoon and evening; all-day Saturday and Sunday.

Consent and Mental Capacity Act

- **Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. They followed the service policy and procedures when a woman could not give consent. All staff were aware of the importance for gaining consent from women before conducting any ultrasound scan.**
- 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. The scan assistants checked the form was signed before the women's appointments.
- Women's verbal consent was also sought before the sonographer commencing 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 scan at any time, and we observed this during our inspection.
- 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 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.**
- All staff were very passionate about their roles and were dedicated to making sure women received patient-centred care.
- We observed staff treating and assisting women and their families in a compassionate manner. The scan assistants and sonographer were very reassuring and interacted with the women and their relatives in a professional, respectful, and supportive way.
- During our inspection of Window To The Womb, we spoke with four women and their partners about various aspects of their care. Without exception, feedback was consistently positive about the kindness and care they received from staff. One woman described staff as "really friendly and welcoming". Another woman told us that she would recommend the service and that she "would definitely use the service again".
- We observed staff introducing themselves to women at the start of the appointments, and the women we spoke with confirmed this.
- Staff protected women's privacy and dignity. For example, the clinic room was locked when ultrasound scans were being undertaken, and women were

provided with a gown to cover themselves during intimate scans. There was also a dignity screen for women to get changed behind before their transvaginal scans. A woman told us that she felt that the sonographer treated her with dignity during her internal scan.

- The service obtained patient feedback through feedback forms, which allowed women to make comments about their care and provide a rating of their overall experience. We reviewed a sample of the feedback forms (13 forms in total), and found that all the women had rated their experience as 'five stars'. Examples of comments included, "amazing experience, I felt really comfortable", "very patient and kind staff, made my absolute day", and "such a lovely, comfy, supportive environment".
- We also read some feedback from women, that had been sent by letter, email, or on social media. All the feedback was extremely positive, and included comments such as, "staff did everything they could to accommodate our tricky request and it turned out to be the best scan we had so far", "the staff were brilliant, they made me and my partner very welcome", and "I loved every single scan I had here… 100% recommend".

Emotional support

- **Staff provided emotional support to women to minimise their distress. We observed staff providing kind, thoughtful, supportive, and empathetic care.**
- Staff were aware that women attending the service were often feeling nervous and anxious so provided additional reassurance and support to these women. The scan assistants acted as chaperones during intimate ultrasound scans to ensure women received emotional support. As part of their mandatory training, staff received training in the emotional aspects of receiving bad news.
- In the case of abnormal results, for example, a miscarriage, women could remain in the scan room with their partner or, if they were unaccompanied, call their partner or relative in private. If a woman suffered a miscarriage before their appointment, staff immediately refunded the woman's deposit payment.
- If a woman became distressed in a public area, such as the waiting room, they allowed the woman to sit in the staff room, where a member of staff would support them.

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.**
- Staff took the time to explain the procedure to the woman before and during the ultrasound scan. Staff adapted the language and terminology they used when discussing the procedure with the woman and her family, and feedback from women confirmed this. They told us that the sonographer explained what was happening throughout their appointment, and they were provided with the opportunity to ask questions about their scan and its findings.
- Staff also communicated to relatives in a way they could understand. This included any children who may have accompanied the woman to their appointment. The registered manager told us that up to five people were welcome to attend the appointments with the woman.
- All relatives we spoke with said that they felt involved in the care given.

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 facilities and premises met the needs of the range of people who accessed the service. This included children who accompanied women to their scans. The service also recognised that women's preferred method of communication had changed, and as a result, they had developed a range of innovative products to tailor their services and meet the needs of local people.**

Good

Diagnostic imaging

- The clinic was located on the first floor of a medical centre, and was accessible to all women and visitors; there was ramp and lift access to the building, and the clinic room contained an adjustable couch, which staff used to support women with limited mobility. There was also a comfortable waiting area, with a water dispenser, a fridge containing soft drinks and confectionary, and two patient toilets, including a disabled toilet and baby changing facilities.
- Children frequently accompanied women to their appointments. In these circumstances, staff ensured the children felt involved, and gave them a 'big sister' or 'big brother' sticker for any scans completed after 16 weeks' gestation. In addition, the waiting area contained children's toys and colouring books.
- There was a small car park to the rear of the building, which offered two hours free parking. The clinic was also located close to public car parks and transport, which were all within walking distance. The service provided information on travelling to their clinic on its website.
- Window To The Womb offered a range of ultrasound scans for pregnant women, such as wellbeing, viability, growth, presentation, and gender scans.
- There was a range of appointment times, including daytime, evening, and all-day weekend clinics. The service operated seven days a week and worked in a flexible way to accommodate the needs of women and their families.
- Women were given relevant information about their ultrasound scan when they booked their appointment, such as needing a full bladder. This information was also included in the 'frequently asked questions' on the service's website.
- 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 during their appointments.
- The service recognised that women preferred to use the internet or mobile phone applications ('app') to contact the clinic and book appointments. Therefore, women could book their scan appointments through the phone, website or through the free Window To The Womb phone app. The app also enabled women 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. Any scan image taken during a Window To The Womb appointment was also saved on the app. This enabled women to have instant access to their scan images.
- Window To The Womb regularly used social media to engage with the local population and promote their service.

Meeting people's individual needs

- **The service took a proactive approach to understand women's individual needs, and delivered care in a way that met these needs, which was accessible and promoted equality.**
- Women received written information to read and sign before their scan appointment, which was available in different languages. Copies of this document, and other key information were also available on the website and could be accessed in any recognised world language. For example, the website contained information about what an ultrasound scan involves and advice about some pregnancy conditions, including cleft lip, anencephaly, and spina bifida.
- At the time of our inspection, there was not a translation service for staff to use during an appointment for non-English speaking women. However, we were told that the franchisor was developing a bespoke mobile phone app for staff and women to use in these circumstances. Once developed, the app translated both verbal and written information. The franchise director hoped the app would be implemented by March 2019.
- Easy to read and large print information leaflets were available for women who had sight impairment. The service also used an online 'read aloud' function.
- Information leaflets were given to women 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.

Good

Diagnostic imaging

- All scans were undertaken in a private clinic room with lots of space for any additional relatives, friends, or carers to accompany the woman. If a woman was required to undress, locked doors and dignity screens were used to protect her privacy.
- The moveable couches were suitable for very overweight women; however, there was no hoist available. If a woman required the use of other bariatric equipment, they would be referred to the NHS.
- Staff did not know if a woman had a learning disability before they arrived at the clinic. However, staff told us that they had not seen a woman with a known learning disability since they opened in 2014. If they did see a woman with a learning disability, staff told us they would provide her with individualised care and ensure she was accompanied by a relative, friend or carer.
- Window To The Womb separated their services into two clinics: the 'Firstscan' clinic, which specialised in early pregnancy scans; and the 'Window to the womb' clinic, which offered later pregnancy scans. Although the Firstscan clinic was operated within Window To The Womb and was provided by the same staff, appointments were offered at different times. This meant that women who may have experienced a miscarriage did not share the same area with women who were much later in their pregnancy.
- The service offered women a range of baby keepsake and souvenir options, which could be purchased for a small fee at reception. This included heartbeat bears, a selection of photo frames, fridge magnets and gender reveal products. Heartbeat bears contained a recording of the unborn baby's heartbeat.

Access and flow

- **Women could access services and appointments in a way and at a time that suited them. Technology was used innovatively to ensure women had timely access to treatment.**
- All women self-referred to the service. They could book their appointment in person, by the telephone, using the online booking form or the app.
- The service operated seven days a week, which meant there was a range of appointments available. This included evening and weekend clinics. Same day appointments were also often available. All the women we spoke with confirmed they had a choice of appointment times.
- At the time of our inspection, there was no waiting list or backlog for appointments. From January to December 2018, the service performed 5,617 ultrasound scans. This included 1,569 early pregnancy scans and 4,048 later pregnancy scans.
- During our inspection, we observed that the Firstscan and Window to the Womb clinics ran on time.
- The service monitored their rates of patient non-attendance, and the registered manager submitted this information to the franchisor every month. There was a low rate of non-attendance because the service requested a non-refundable deposit payment on appointment booking. If a woman suffered a miscarriage before their appointment, staff would refund the deposit payment immediately.
- From July to December 2018, data showed that 19 women did not attend their booked appointment at the Firstscan clinic. For the same period, 27 women did not attend their appointment for the later pregnancy clinic.
- From January to December 2018, no ultrasound scans were delayed or cancelled for non-clinical reasons.

Learning from complaints and concerns

- **The service treated concerns and complaints extremely seriously. The registered manager completed comprehensive investigations, which frequently involved input from other professionals, such as the lead sonographer. Lessons learned were shared with all staff.**
- The service had an up-to-date complaint handling policy, which set out the complaints process and the responsibility of staff. The policy confirmed that all complaints should be acknowledged within three working days and resolved within 21 working days.

Good

Diagnostic imaging

- The registered manager had overall responsibility for reviewing and responding to complaints. They collated complaints into an electronic log, which was used to identify any themes and learning, and was shared with staff at their team meetings.
- From January to December 2018, the service received eight complaints. We saw that action was taken in response to the complaints received to help improve patient experience and service provision. For example, following a concern about a gender confirmation scan, the registered manager asked the lead sonographer to review the scan images. The woman was also invited back for another gender scan free of charge and offered a complimentary 4D scan. The sonographer involved was asked to review the scan video and received additional support from the lead sonographer.
- While we saw that appropriate action was taken to resolve the complaints, the complaint log did not contain an 'acknowledged by' or 'responded by' date. This meant we were unable to determine whether complaints were acknowledged, investigated, and closed within the required timescale. However, the registered manager assured us that they resolved all complaints within 48 hours.
- Following our inspection, the registered manager provided evidence that the last two complaints they received were acknowledged and resolved within 24 hours. Both women were also offered a complimentary 4D scan for their inconvenience. We were also provided with the service's updated complaints log, which now included an 'acknowledged by' and 'responded by' column.
- Information on how to make a complaint was available on the clinic website and on the back of the patient feedback form. Staff told us that most complaints were made through social media. Therefore, the registered manager monitored their social media pages daily, which ensured any concerns or complaints were addressed immediately.
- All had staff completed a mandatory training course on customer care and dealing with complaints.

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 registered manager had the skills, experience, and integrity needed to run a sustainable service.**
- The manager 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.
- The sonographers reported to the registered manager for matters of administration and to the lead sonographer for clinical matters. The scan assistants reported to the registered manager. One of the scan assistants had recently been promoted to a team leader, and was responsible for the day-to-day running of the service in the absence of the registered manager.
- Staff knew the management arrangements and told us they felt well supported. The lead sonographer was available to review any ultrasound scan remotely within one to two hours.
- All staff spoke overwhelmingly positively about the registered manager of Window To The Womb and the franchise directors. They said the manager and directors were friendly, approachable, and effective in their roles. Staff felt confident to discuss any concerns they had with them.
- Management development courses were available, and could be accessed by any member of staff. The courses included: customer service skills, manager induction, negotiating and influencing, problem solving and performance appraisals. The registered manager had successfully completed the development courses.
- The franchisor was contractually responsible for providing the registered manager with ongoing training, which was undertaken at clinic visits, training events and the biannual national franchise meetings.

Good

Diagnostic imaging

Vision and strategy

- **Window To The Womb had a clear vision and strategy for what they wanted to achieve, with quality and sustainability as the top priorities.**
- Their vision was "to provide high quality, efficient and compassionate care to their customers and families, through the safe and efficient use of obstetric ultrasound imaging technology". 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".
- 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. Staff told us they "aimed to provide the best possible customer experience".
- The service had also identified values, which underpinned their vision. Their values included: dignity, integrity, privacy, diversity, and safety.
- There were plans to relocate the service to a new, larger location within Watford by the end of the financial year. However, at the time of our inspection, this had not yet been formally agreed.

Culture

- **Managers 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 five 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 Window To The Womb. 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 franchisor's 'freedom to raise a concern' policy, and the appointment of a 'freedom to speak up guardian'. There was also a confidential phone line for staff to contact should they wish to discuss anything that had affected them at work.
- Any incidents or complaints raised had a 'no blame' approach to the investigation. However, in circumstances where errors had been made, apologies would always be offered to the woman, and staff ensured 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 registered manager 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.

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. Managers also did not have full oversight of what training the sonographers had completed at their substantive employer. However, these concerns were addressed immediately after our inspection.**
- The registered manager had overall responsibility for clinical governance and quality monitoring. This included investigating incidents and responding to patient complaints. The registered manager was supported by the franchisor and attended biannual national franchise meetings, where clinic compliance, performance, audit, and best practice were discussed.
- There was an audit programme in place to provide assurance of the quality and safety of the service. Peer review audits were undertaken in accordance with recommendations made by the British Medical Ultrasound Society, and the franchisor completed annual sonographer competency assessments. Other

audits, such as clinical and local compliance audits were undertaken regularly. They monitored patient experience, health and safety, equipment and privacy and dignity.

- While the service did not hold formal clinical governance meetings, staff meeting minutes demonstrated that complaints, incidents, audit results, patient feedback, and service changes were discussed and reviewed. The registered manager told us informal discussions with staff were also held in between the team meetings.
- At the time of our inspection, there was not a robust process in place to monitor and review what training the sonographers had completed at their substantive employer. There was also 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 sonographer staff files contained evidence of employment references. This meant we could not be assured that Window To The Womb 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 registered manager provided evidence which showed that sonographer references, appraisals and their mandatory training matrix had been requested and stored in their staff personnel files. The recruitment policy was also amended to reflect the new staff requirements.
- All staff were covered under the service's medical malpractice insurance, which was renewed in October 2018. The sonographers also all held their own indemnity insurance.

Managing risks, issues, and performance

- **The service had effective arrangements in place for identifying and recording risks, and there was evidence that these risks and their mitigating actions were discussed with the wider team.**
- The service did not hold a risk register; however, risk assessments were completed for any identified risks. At the time of our inspection, five risk assessments had been undertaken, including fire, health and safety, legionnaires' disease, the Control of Substances Hazardous to Health Regulations (COSHH) and an assessment for the registered manager owning two Window To The Womb franchised clinics. All five risks had been graded as 'low risk'.
- Risk assessments were completed on a standard template to ensure consistent information was used. All templates had the risk identified, mitigating/ control measures, the individual responsible for managing the risk and the risk assessment review date. There was also evidence that the risk assessments had been circulated to all employees and the management team for review.
- Most staff could clearly articulate the main risks to the service and what was being done to address them.
- There were appropriate policies in place regarding business continuity and major incident planning, which outlined clear actions staff needed to take in the event of extended power loss, a fire emergency, severe weather, or other major incident. They also contained contact details of relevant individuals or services and an emergency response checklist.
- The service used key performance indicators (KPIs) to monitor performance, which were set by the franchisor. This enabled the service to benchmark themselves against the 35 other franchised clinics. At the time of our inspection, the registered manager reported that they were in the top five performing clinics for both their later and early pregnancy services.
- The registered manager compiled a monthly performance report, which outlined the number and type of complaints received, the number of ultrasound scans completed including the number of rescans, the number of women who did not attend their appointment and the number of referrals made to other healthcare services.
- The service was regularly exceeding the target for the number of completed ultrasound scans. The franchisor set a KPI of 50 scans per week, and the Watford clinic saw between 65 to 75 women at their later pregnancy clinic and approximately 30 women during their Firstscan clinic each week.

- The service also used patient feedback, complaints, and clinical audit results 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.
- Window To The Womb 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.
- Patient records and scan reports were easily accessible and were kept secure. Paper records were stored in locked filing cabinets and staff locked computer terminals when not in use. All electronic records and systems were password protected, and the passwords were changed every time a staff member left the service.
- Information from scans could be reviewed remotely by referrers to give timely advice and interpretation of results to determine appropriate patient care.

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. Patient feedback was gathered through feedback forms, which allowed women to make comments about their care and provide a rating of their overall experience. We reviewed a sample of the feedback forms, and found all the women had rated their experience as 'five stars'. All the comments made were also overwhelmingly positive.
- 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. Similarly, women were encouraged to leave feedback on the service's social media pages. For example, one woman commented, "the staff were brilliant, they made me and my partner very welcome. Would highly recommend". The social media pages were monitored daily as staff recognised that this was women's preferred method of communication.
- Patient feedback was taken seriously and used to improve the service. For example, following patient feedback, the service: increased their staffing to reflect their expanding service; purchased a dignity screen for the clinic room; replaced furniture in the reception, and adjusted their opening times to suit demand.
- Patient feedback and complaints were discussed with the team during staff meetings.
- Team meetings were held monthly, and staff told us that the meetings helped to make them feel actively engaged in service planning and development.
- The registered manger recently introduced a new set agenda to improve the structure and consistency of the meetings. We reviewed the team meeting minutes held in January 2019 and saw that changes to service provision and performance, complaints, patient feedback, audit results and staff training were discussed.
- The sonographers were unable to attend the team meetings due to other work commitments. Therefore, the registered manager sent a monthly email to update them on any important information or changes. The team meeting minutes were also circulated by email and a paper-copy was available on the noticeboard in the staff room.
- The staff noticeboard also contained other important information for staff to read, such as updated policies, the mandatory training schedule, staff rotas and the

corporate newsletter, called 'Open Window'. Open Window was sent to all franchises every six to eight weeks, and included important updates, such as CQC inspections, new clinics, and changes to e-learning.

Learning, continuous improvement and innovation

- **Staff could provide examples of improvements and changes made to processes based on patient feedback, incidents, and staff suggestion.**
- The service had developed a mobile phone application ('app') to support and engage with women. The app enabled women 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. Any scan image taken during a Window To The Womb appointment was also saved on the app, which enabled women to have instant access to their scan images. Women could also book their scan appointments through the app.
- The registered manager took immediate and effective actions to address some of the concerns we raised during the inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should consider carrying out regular hand hygiene audits to monitor and improve infection prevention and control practices.
- The provider should ensure there are effective governance arrangements in place to assure themselves that staff are competent, of good character and suitable for their role.
- The provider should ensure there are translation services available for staff and women to use during an ultrasound appointment.