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

Overall summary

Window to the Womb in Liverpool is owned by 1st Glimpse 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 Merseyside and Cheshire.

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

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

Summary of findings

needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided by this clinic was diagnostic imaging.

Services we rate

We have not previously rated this service. We rated it as **Good** overall.

We found the following areas of good practice:

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care. Managers appraised staff's work performance annually and checked to make sure staff had the right qualifications and professional registration for their roles.
- Staff assessed risks to women, they kept clear records and asked for support when necessary. Staff kept records of women's appointments, referrals to NHS services and completed scan consent documents.
- The service provided care based on national guidance. The service checked to make sure staff followed guidance through local audits, annual clinical audits and peer review.
- The service controlled infection risk well. The clinic had suitable premises and equipment which met the needs of people who accessed the service. This included people who accompanied women and children.
- The service made innovative use of technology to provide women with ways to access the service and their scan images. They had developed a mobile phone application which enabled women to document and share weekly images of their pregnancy 'bump'. They used social media to provide instant information on frequently raised questions and concerns.
- Window to the Womb had clear governance arrangements that were appropriate to the size and scope of the service. Senior managers from the franchisor actively engaged with managers of 1st Glimpse Ltd and clinic staff. All managers promoted a positive culture that supported and valued staff.

However, we also found the following issues that the service provider needs to improve:

- Managers could not assure themselves that all staff would identify and respond appropriately to the needs of vulnerable women attending for multiple scans.
- The service did not have access to translation services for staff to use with women who did not speak English during scan appointments.

Following this inspection, we told the provider that it should make some improvements, even though a regulation had not been breached, to help the service improve.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North)

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.

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 operated by 1st Glimpse Ltd. It is a private clinic in Liverpool, Merseyside.

The Liverpool clinic opened in 2016 and primarily serves the communities of Merseyside and Cheshire, though it also accepts women from outside this area.

The clinic has had a registered manager in post since October 2016. At the time of the inspection, a new manager had recently been appointed and was registered with the CQC in October 2018. They were on a leave of absence and the registered manager for the clinic in Manchester was acting as manager at this clinic. The provider notified CQC of this change on 17 January 2019.

The clinic provided baby scans including early pregnancy scans, well-being checks, growth and presentation scans and 4D scans including keep sakes and souvenirs.

We have not previously inspected this service.

Our inspection team

The team that inspected the service comprised two CQC inspectors. The inspection team was overseen by Nicholas Smith, Head of Hospital Inspection.

Information about Window To The Womb

The clinic is in south Liverpool and has one scan room, a reception area, waiting room and separate room used for sensitive discussions. It is located on the ground floor of a business unit and is fully accessible. The clinic is registered to provide the following regulated activities:

- Diagnostic and screening procedures

Window to the Womb has separated their services into two clinic types. 'Firstscan' clinic sessions specialise in early pregnancy scans up to 16 weeks gestation. 'Window to the Womb' clinic sessions offer later pregnancy scans. The Firstscan and Window to the Womb sessions take place at different times.

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

The clinic opens four days a week including at weekends and evenings.

At the time of our inspection the clinic employed one registered manager, one sonographer and five scan assistants. The service did not employ any medical staff. The clinic did not use controlled drugs.

During the inspection, we visited all areas of the clinic including the reception area, waiting room and the scan room. We spoke with six staff including managers, sonographers, baby scan assistants and senior managers. We spoke with six women and four relatives. During our inspection, we reviewed 11 sets of patient records and observed seven scans.

There were no special reviews or investigations of the clinic ongoing by the CQC at any time during the 12 months before this inspection. This was our first inspection of this provider and clinic.

Activity (January to December 2018)

- In the reporting period January to December 2018 there were 2,498 Window to the Womb scans recorded at the clinic; these were all privately funded.
- In the reporting period August to December 2018 there were 524 early pregnancy scans (Firstscan) recorded at the clinic.
- The service scanned 2,280 women in the reporting period.

Track record on safety

Summary of this inspection

- The clinic had no serious incidents or never events in the reporting period.
- There have been no Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) or Ionising Radiation Regulations 2017 (IRR17) reportable incidents in the reporting period.
- There have been no incidences of clinic acquired infections.
- The clinic transferred one woman to another healthcare provider due to a suspected complication.
- The clinic received four complaints between January and December 2018, one of which was upheld.

The clinic does not have any services accredited by a national body.

The clinic does not provide any services under service level agreement.

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 have not previously rated this service. We rated it as

We have not previously rated this service. We rated it as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to safeguard people from abuse and had completed training at the required level on how to recognise and report abuse. Staff knew how to apply this training.
- The service controlled infection risk well. Staff kept equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- The service had appropriate arrangements in place to assess and manage risks to women, their babies and families.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of women's appointments, referrals to NHS services and completed scan documents. Records were clear, up-to-date and readily accessible to staff.
- The service had appropriate processes for staff to raise concerns and report incidents. Staff understood their roles and responsibilities to raise concerns and record safety incidents.

However,

- Staff we spoke with did not show an understanding of the underlying reasons women may present for multiple scans. This meant there was a risk that they may not identify women with specific needs such as mental health or experiencing abuse and, as such, may not sign post them to appropriate support.

Are services effective?

We do not rate effective for diagnostic imaging services. However, we found:

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff monitored the effectiveness of care and treatment and used the findings to improve their practice.

Summary of this inspection

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and there were processes in place to assess sonographer competence and suitability for their role.
- Staff of different kinds worked together as a team to benefit women and their families.
- Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. Staff followed the service policy and procedures when a woman could not give consent. All staff were aware of the importance of gaining consent from women before conducting an ultrasound scan.

Are services caring?

Good

We have not previously rated this service. We rated it as **Good** because:

- Staff cared for women and their families with compassion. We saw positive interactions between women and staff. Feedback from women confirmed that staff treated them well and with kindness.
- Staff provided emotional support to women and their families. The clinic had a dedicated 'quiet room' for staff to have sensitive and distressing conversations with women.
- Staff involved women and those close to them in decisions about their care and treatment.

Are services responsive?

Good

We have not previously rated this service. We rated it as **Good** because:

- The service planned and provided services in a way that met the range of needs of people accessing the clinic. The facilities and premises met the needs of women and families, including children, that accompanied women to their scan.
- The service took account of women's individual needs and delivered care in a way that met these needs.
- People could access the service when they needed it. The clinic opened on evenings and weekends.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Are services well-led?

Good

We have not previously rated this service. We rated it as **Good** because:

Summary of this inspection

- Managers at all levels had the right skills and abilities to run a sustainable service.
- Window to the Womb had a vision and strategy for what it wanted to achieve and the clinic had a clear business plan to turn this into action.
- All managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service systematically improved service quality through regular audits and clinical reviews by lead clinicians employed by Window to the Womb (Franchise) Ltd.
- The service had systems to identify risks and plan to reduce them. The service completed risk assessments for identified risks
- The service managed and used information to support its activities, using secure electronic systems.
- The service engaged well with women, staff and the public to plan and manage appropriate services and collaborated with partner organisations well.
- The service was committed to improving services by learning from when things went well or wrong and promoting training.

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

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. We rated it as **good.**

Mandatory training

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Mandatory training requirements, including topics covered and frequency of training for each role were defined in the mandatory training policy.
- The service provided an annual programme of mandatory training, which staff accessed through face to face sessions and online training. The registered manager attended an external mandatory training course each year.
- We reviewed training files for all staff and saw all had completed the required mandatory training for their role in the last 12 months.
- All staff attended a mandatory induction day when first employed. Staff we spoke with told us they had a period of job shadowing when they first started to learn the requirements of their role.

Safeguarding

- Staff understood how to safeguard people from abuse and had completed training at the required level on how to recognise and report abuse. Staff knew how to apply this training.
- All scan assistants and the sonographer had completed level two training in safeguarding adults and children. Registered managers had completed level three safeguarding adults and children training. The service provided scenario based refresher safeguarding training to staff every six months.
- Registered managers were the designated lead for safeguarding and were trained to level three safeguarding adults and children. They attended the clinic when open or if they were not able to attend, were available 'on call'. This meant staff had access to advice from a level three trained member of staff during opening hours.
- Staff we spoke with understood how to recognise and report safeguarding concerns and told us all safeguarding concerns would be reported to a manager. Staff could access information and advice about safeguarding from the training resource folder which included information on the Mental Capacity Act, how to report safeguarding concerns and how the safeguarding children board worked. It also included a flow chart to inform staff how to follow the safeguarding process.
- We reviewed the safeguarding policy and saw it was in date and included relevant local and national contact details for reporting safeguarding concerns.
- The service had a separate female genital mutilation (FGM) policy that provided staff with clear guidance on how to identify and report concerns. Staff we spoke with were aware of the importance of recognising FGM and told us they would escalate concerns through the safeguarding process.

Good

Diagnostic imaging

- The service required all staff have a Disclosure and Barring Service check as part of the recruitment process. The service repeated the check every three years for registered managers and baby scan assistants and annually for sonographers.
- At the time of our inspection, two baby scan assistants had applied for a Disclosure and Barring Service check but these had not been received. Managers told us the staff would not work alone with any woman until this had been received. We saw evidence that the registered manager had tracked the progress of the outstanding checks regularly and there was a risk assessment in place for staff whilst awaiting the outcome of the check.
- However, staff we spoke with did not show an understanding of the underlying reasons women may present for multiple scans. This meant there was a risk that they may not identify women with specific needs such as mental health or experiencing abuse and, as such, may not sign post them to appropriate support.

Cleanliness, infection control and hygiene

- The service controlled infection risk well. Staff kept equipment and the premises clean. At the time of our inspection all areas of the clinic were visibly clean and clutter free. We saw all posters displayed in clinical areas were laminated to make them easy to clean and prevent the spread of infection.
- The service had infection prevention and control policies in place, which provided staff with guidance on appropriate infection control practice. Staff had completed an infection control risk assessment in June 2018, which was reviewed annually and identified control measures staff should use to prevent the spread of infection.
- Staff recorded daily cleaning and the monthly deep cleaning on a checklist. We reviewed the cleaning checklists for December 2018 and January 2019 and saw that daily and monthly cleaning had taken place. Staff checked the cleanliness of the toilet every hour, we saw hourly checks were recorded by staff throughout January 2019.
- Staff used control measures to prevent the spread of infection. There were hand washing facilities in the scan room and we saw staff used these between each scan. Staff used gloves when scanning women and we saw that if they had to do another task, such as writing notes, they removed the gloves and used hand sanitising gel and new gloves before starting the scan again. Staff followed the World Health Organisation 'Five Moments for Hand Hygiene' and 'bare below the elbows' guidance. Hand sanitising gel was also available for staff, women and visitors to use at the reception desk.
- The service introduced a hand hygiene audit tool in January 2019 to measure staff compliance with these standards. However, the first audit had not taken place at the time of our inspection.
- Staff used disposable paper towel to cover the examination couch during the scan. We saw staff cleaned the bed with sanitising wipes and changed the towel after each scan.
- Staff cleaned the ultrasound probe after each scan with sanitising wipes. They cleaned the ultrasound machine at the end of each day with sanitising wipes. Staff told us the transvaginal probe was cleaned with a high-level disinfectant foam between each use and the batch number of the disinfectant foam recorded on every patient record form.
- There had been no incidents 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 clinic was located on the ground floor of a suite of offices within a business park. It had a bright, welcoming reception area, large waiting room, scan room and another room used as a 'quiet room' as well as toilets and a staff kitchen. The rooms were accessible to all women and visitors including those with disabilities.
- The reception area contained seating for women and visitors to complete paperwork before going into the large waiting area. There were signs above the seats stating, 'reserved for mummies-to-be'. The waiting area was comfortably furnished with sofas and a play area and toys for children.

Good

Diagnostic imaging

- The scan room had adequate comfortable seating for those attending the scan with the woman, including a sofa and chairs. The examination couch was height adjustable. There were three large wall mounted monitors so women and those attending with them could view the scan comfortably from all areas of the room. All electric wires were securely contained behind the ultrasound machine.
- The windows in the scan room were blacked out, to darken the room and ensure scans could be seen and privacy was maintained. Staff locked the scan room door when a scan was in progress to prevent anyone entering accidentally and to promote privacy and dignity. The service provided a screen for women to change behind if they had a transvaginal scan.
- We saw the service completed a health and safety premises risk assessment in June 2018 and this was to be repeated annually. The risk assessment identified appropriate control measures and any staff training required.
- All electronic equipment was maintained in line with the Electricity at Work Regulations 1989 and we saw it was certified until January 2020.
- The service had an up-to-date fire risk assessment and we saw a preventative maintenance visit had taken place in October 2018. We saw evidence of quarterly fire alarm tests and fire drills.
- Staff stored substances which met the Control of Substances Hazardous to Health regulations in a locked cupboard. A risk assessment was completed in June 2018 and reviewed annually. These were all complete and up-to-date.
- The service had a service level agreement with an external company for the repair and servicing of the ultrasound machine. We saw the machine had been installed and handed to the clinic in November 2017 and had received an annual service in January 2019.
- The service stored clinical waste in a separate yellow bin and when full, the bag was placed in a locked bin outside the premises. This was collected every month by an external company. We reviewed collection records for October 2018 to January 2019 and all clinical waste had been collected.

Assessing and responding to patient risk

- The service had appropriate arrangements in place to assess and manage risks to women, their babies and families. Staff kept clear records and asked for support when necessary.
- The service had clear processes and pathways with local NHS providers for staff to follow if any abnormalities were found on an ultrasound scan. Staff told us if an abnormality was detected they would call the local early pregnancy unit or emergency gynaecology department to make an appointment as well as completing the referral paperwork which the woman would take with her.
- We saw the sonographer completed a referral form which included a checklist to ensure they had included all relevant information. The referral form was reviewed by the registered manager and documented on an electronic system.
- The service referred six women to NHS providers for another scan in December 2018 and seven in January 2019. We reviewed these referral forms and saw they contained a description of the scan findings, the reason for referral, who the receiving healthcare professional was and agreed action. We saw all paperwork had been fully completed and was securely stored.
- One woman was transferred to NHS care in an emergency between January and December 2018. We saw staff had called an emergency ambulance in line with the service's policy.
- The service advised all women to bring their NHS pregnancy notes with them so sonographers had access to their pregnancy and medical history. Staff told us if a woman did not bring her notes they would call her GP or midwife before carrying out a scan. Staff made sure women understood that the ultrasound scans they provided were in addition to their routine maternity care and advised any woman who had missed a 12-week scan to register with a midwife.
- The sonographer completed a pre-scan checklist which checked the woman had presented her hospital notes and that the sonographer was satisfied the service was appropriate for the woman. We reviewed 11 checklists and saw they were all fully completed in line with local policy.

Good

Diagnostic imaging

- All women completed a pre-scan questionnaire that included pregnancy history. This included a declaration signed by the woman which gave consent to pass medical information to an NHS care provider if needed and a confirmation that she was receiving appropriate pregnancy care from the NHS.
- Managers told us they had not had women travel from overseas for a scan at this clinic. However, they would follow Window to the Womb policies and refer this to the central team before offering her an appointment.
- The service used the 'Paused and Checked' checklist devised by the British Medical Ultrasound Society and Society of Radiographers. We saw the sonographer completed the checks during scans, which included confirming the woman's identity and consent, providing clear information and instructions, and informing the woman about the results.
- Due to the nature of the service, there was no emergency resuscitation trolley on site. However, staff could access a first aid box and the registered manager had up-to-date first aid training. There was an accident book to record all accidents, none were recorded in 2018.

Staffing

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- All staff were directly employed by 1st Glimpse Ltd on a zero-hours contract. Scan assistants were responsible for managing enquiries, appointment bookings, supporting sonographers during ultrasound scans and helping the families print their scan images.
- Staff did not work on their own and there was always a minimum of three staff on site when the clinic was open including a baby scan assistant, a sonographer and a manager. The service ensured there was always a sonographer and baby scan assistant in the scan room when scans took place.
- At the time of our inspection the registered manager had taken an unplanned leave of absence. The service had provided appropriate cover through the registered manager from another clinic. Each clinic opened at different times so the registered manager providing cover could be on site when the clinic was open.
- Two baby scan assistants had left the clinic in 2018 but the service had recruited four. Managers told us that they had a high volume of applications for any vacancies they advertised. The service used social media to advertise vacancies and followed a robust recruitment procedure which included Disclosure and Barring Service checks.
- The service did not use bank or agency staff. If cover was needed for the sonographer, for example due to annual leave, a sonographer from elsewhere in the 1st Glimpse Ltd group would be relocated to cover the clinic.
- The registered manager monitored staff sickness rates. From January to December 2018 there had been no staff sickness absences.

Records

- Staff kept detailed records of women's appointments, referrals to NHS services and completed scan documents. Records were clear, up-to-date and readily accessible to staff.
- The sonographer completed a paper scan report during the appointment with the support of the baby scan assistant. The woman was given a copy of the report to take away. The sonographer sent a copy of the scan report to the woman's GP or other relevant healthcare professional when a referral was made.
- The service stored completed scan reports in the woman's records. We reviewed 11 records and saw that all scan reports had been fully completed and clearly recorded. They contained pre-scan questionnaires and signed consent forms. If a referral had been made to an NHS provider the referral was recorded in the notes. Records were stored in a locked filing cabinet in reception. They could be easily accessed by all relevant staff.
- Managers audited correct completion of patient records every month. We reviewed the audit for December 2018 and saw no issues had been identified.

- Baby scan assistants recorded the unborn baby's heartbeat on a small electronic device during the scan. If women did not purchase a heartbeat soft toy the recording was cleared after 24-hours.
- The ultrasound images were recorded onto a memory stick which the woman could buy. Images were also available on a mobile phone application. Women were given a secure unique access code for the application and women could then access and download images if they chose to. This meant that women had instant access to their scan images and images remained confidential until women chose to share them.
- Access to the ultrasound machine was password protected and restricted to the sonographer and registered manager.
- The clinic had an up-to-date data retention policy which detailed staff responsibilities, record security measures and retention periods.

Medicines

- The service did not use any medicines or controlled drugs.

Incidents

- The service had appropriate processes for staff to raise concerns and report incidents. Staff understood their roles and responsibilities to raise concerns and record safety incidents.
- The service used a paper-based reporting system for staff to report an incident. This was collated and a computerised record kept by the registered manager. The service reported no incidents between January and December 2018.
- Staff we spoke with knew how to report incidents and could give examples of when they would do this.
- From January to December 2018 the service had no never events. A never event is a serious incident that is preventable and has the potential to cause serious patient harm or death.
- The service did not report any serious incidents from January to December 2018.
- Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The service had not needed to do this but staff we spoke with were aware of the term and the principle behind the regulation and the need to be open and honest with women where incidents occurred.
- Managers were aware of the requirements for reporting incidents and submitting notification to the CQC. They had submitted a notification regarding the absence of the registered manager in a timely manner.

Are diagnostic imaging services effective?

We do not rate effective.

Evidence-based care and treatment

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Local policies and protocols were up-to-date, written by the clinical lead, a diagnostic sonographer and clinical nurse specialist and reviewed by the lead sonographer and a consultant in obstetrics and gynaecology. They followed national guidance from the Royal College and Society of Radiographers, the foetal abnormality screening programme standards and British Medical Ultrasound Society . For example, the service did not offer transvaginal scans to women over 10 weeks gestation in line with this guidance.
- The service provided a handbook for sonographers which referenced relevant Society and College of Radiographers standards and guidance, guidance on CQC registration and national guidelines on safe use of doppler.
- The service followed the as low as reasonably achievable principles outlined by the Society and College of Radiographers. This meant that sonographers did not scan for longer than 10 minutes and would not repeat scan within seven days of the previous scan.
- The service had an audit programme to assure itself of the quality and safety of the clinic. The franchisor (Window to the Womb Ltd) completed annual

sonographer competency assessments and an annual clinic audit. Peer reviews took place in line with British Medical Ultrasound Society recommendations. The registered manager completed monthly clinic audits.

- The franchisor employed a consultant radiographer to advise the board on compliance with national standards and ensure policies and strategy was in line and best evidence-based practice.

Nutrition and hydration

- The service did not offer food and drink to women but there was a drinking water dispenser in the reception area for women and visitors. Staff gave women appropriate information on drinking water before a scan to ensure they attended with a full bladder.

Pain relief

- Staff did not formally monitor pain levels as the procedure is pain free. However, we saw staff asked women if they were comfortable during their scan.

Patient outcomes

- Staff monitored the effectiveness of care and treatment and used the findings to improve their practice. The service monitored patient outcomes and experience through their monthly clinic audits and patient satisfaction feedback cards.
- The service used key performance indicators to monitor performance, which were set by the franchisor. They benchmarked themselves against the other clinics in the group for number of reviews received, number of rescans and number of completed scans. We reviewed performance against indicators in December 2018. The franchisor set a target for scan processing time of 60 minutes, the service achieved 55 minutes on average. The franchisor set a target for the number for the number of rescans to be 10% or less of the total scans. We saw in December 2018 the service achieved a rescan rate of 3.7%.
- The service reported a 99.9% accuracy rate for gender confirmation scans between January and December 2018.
- From January to December 2018, Window to the Womb clinics completed 166 rescans. For the same period, Firstscan clinics did not complete any rescans.
- The franchisor (Window to the Womb Ltd) carried out an annual compliance audit and we saw the last one had taken place in March 2018. The clinical lead sonographer from Window to the Womb Ltd also carried out an annual clinical review, this was completed in August 2018. Window to the Womb also carried out unannounced 'mystery calls' to the clinic to evaluate the standard of communication between staff and women.
- We saw that compliance with audits was a standing agenda item and discussed at monthly team meetings. Feedback from women and local performance was also discussed at team meetings.
- We saw staff took action to address any concerns raised by monthly clinic audits. For example, we saw the audit in December 2018 identified the need for an annual assessment for the sonographer and this was carried out January 2019.
- Window to the Womb Ltd had a system of peer review for sonographers, which the clinic took part in. The clinic kept scans for one month so sonographers could review each other's work and determine if they agreed with ultrasound observations and report quality.

Competent staff

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and there were processes in place to assess sonographer competence and suitability for their role.
- The sonographer had an annual competency assessment from the clinical lead for Window to the Womb Ltd and this was completed in January 2019. As part of the assessment the lead sonographer checked the sonographer's registration, indemnity insurance and revalidation status. We saw confirmation of the sonographer's registration with the Health and Care Professions Council and letter of good standing with the Society and College of Radiographers was displayed in the clinic.
- We saw the competency assessment included identification of areas for development and an appropriate action plan to address these. For example, following the assessment the sonographer was booked onto additional training in February 2019. When issues were identified through the annual

review the lead sonographer increased the frequency of reviews to every four months and the registered manager carried out monthly reviews with the sonographer.

- The service had a clear performance management process which was understood by all staff we spoke with. The registered manager completed an annual appraisal called a 'care and service assessment' with all staff. All staff had received their appraisal in the last 12 months.
- At the time of our inspection, managers told us they were developing new online training for staff to access for professional development. All staff had received role specific mandatory training and this would be in addition to this.

Multidisciplinary working

- Staff of different kinds worked together as a team to benefit women and their families.
- During our inspection we saw there were strong working relationships between scan assistants and the sonographer. We saw positive examples of them working well together, for example when the sonographer responded positively to a prompt from scan the assistant and worked with the scan assistant to ensure she understood what to write on the scan report.
- The clinic had a daily 'fire up' meeting which all staff attended before the clinic opened. The meeting included confirmation of the women booked for scans that day, discussion of any known issues or concerns and an update on any safety or risk information from the wider Window to Womb group. Staff were given paper copies of the list of scans booked that day.

Seven-day services

- The clinic opened four days a week, Tuesday, Thursday, Saturday and Sunday. It offered evening clinics on Tuesday and Thursday. The time of clinic sessions was designed to accommodate the needs of women and their families, for example evening and weekend appointments enabled working mothers and siblings to attend.
- Women could book appointments online or by telephone at a time to suit them.

Health promotion

- The service provided information leaflets for women which gave information on how to keep healthy during pregnancy, food to avoid during pregnancy and Group B Streptococcus immunisation.

Consent and Mental Capacity Act

- Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. Staff followed the service policy and procedures when a woman could not give consent.
- All women 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 is and is not 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 11 pre-scan questionnaires and foetal wellbeing reports we reviewed.
- All staff were aware of the importance of gaining consent from women before conducting an ultrasound scan. The sonographer confirmed names and spellings and dates of birth prior to the scan and obtained verbal consent to begin.
- Window to the Womb Ltd had a position statement on the Mental Capacity Act (2005) for staff to follow. This outlined the requirements for staff and the process to follow, all staff had signed to say they had read this statement. Managers told us the service was designing a bespoke Mental Capacity Act online training course and it would start at the end of June 2019.

Are diagnostic imaging services caring?

Good

We have not previously rated this service. We rated it as **good.**

Compassionate care

Good

Diagnostic imaging

- Staff cared for women and their families with compassion. Feedback from women was consistently positive and confirmed that staff treated them well and with kindness.
- During our inspection we saw positive interactions between women and staff.Staff built excellent rapport with women and families and were calm and reassuring. The sonographer treated woman with dignity and respect and showed compassion and patience when a woman stated was she was hot. The sonographer did not rush women and checked they were comfortable throughout the scan.
- We reviewed 13 feedback cards displayed around the clinic. All gave the service a five-star rating. We saw comments such as 'thank you so much for fitting us in at the last minute and reassuring us', 'me and my partner and my 3 year old had a lovely experience' and 'calm and relaxing loved it!!'.
- We spoke with six women and four family members. They all spoke positively of the service and praised the staff. One woman and her partner we spoke with were attending for their fourth scan. They told us this was because the experience was 'amazing' and staff had been 'so nice'.
- We saw that staff went the extra mile to ensure women had a positive experience. This was evidenced by comments such as 'baby was not compliant but the staff have done everything to get a good picture' and 'amazing! Fitted me in last minute'.
- We observed a scan assistant talking to a family about what their package included and helping them to choose images. They were warm and friendly and clearly explained how the woman could use and access a mobile phone application to view and share inages.
- Staff protected women's privacy and dignity and the service had a chaperone policy. The scan room was locked when scans were being undertaken and there was a privacy screen for women to get changed behind before transvaginal scans. The service provided towels for women to cover themselves during the scan.

Emotional support

- Staff provided emotional support to women and their families. We saw staff provided kind, thoughtful and supportive care. The scan room provided a calm, supportive atmosphere with relaxing music playing in the background.
- The clinic had a dedicated 'quiet room' for staff to have sensitive and distressing conversations with women. Staff told us this could be used if a woman became distressed or very anxious in a public area.
- If a scan showed abnormal results the woman and her family could remain in the scan room whilst the sonographer explained the scan and arranged an appointment with a NHS provider. Staff told us that women could also choose to wait in the quiet room during this process.
- The service provided training to staff on supporting women who had received bad news and the emotional impact of this.
- Scan assistants had completed bereavement support training and the service provided information on bereavement support services and charities which supported woman following miscarriage.

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 time to explain the procedure before and during the scan. We saw the sonographer fully explained what was happening throughout the scan. They used appropriate language to explain the position of the unborn baby and the images on the monitors and asked women if they had any questions throughout and at the end of the scan. Women we spoke with told us that they had felt involved in the scan.
- Staff communicated with relatives in a way they could understand. We saw they encouraged family members and siblings to be involved with the scan process pointing out features and encouraging a sibling to look at her 'baby brother' on the monitor.
- We observed one scan where a woman had come back after 15 minutes as the sonographer could not get a 4D image due to the position of the unborn baby.

Good

Diagnostic imaging

The sonographer clearly explained that the baby still had not moved and why they could not get a 4D scan. She told them to rebook a free of charge appointment with the manager.

- The service assured women that their scan images were treated confidentially. They gave women a unique access code to a mobile phone application, so they could choose who to share the images with. The sonographer explained they did not export images onto the USB stick whilst the woman is in the room because due to the computer system there is a risk that the people in the room may see another woman's name. She told us she did this when the woman and family had left the room and with the door locked to maintain confidentiality.

Are diagnostic imaging services responsive?

Good

We have not previously rated this service. We rated it as **good.**

Service delivery to meet the needs of local people

- The service planned and provided services in a way that met the range of needs of people accessing the clinic.
- The facilities and premises met the needs of women and families, including children, that accompanied women to their scan. 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 service recognised that women preferred to use the internet or mobile phone to contact the clinic and book appointments. Therefore, women could book their scan appointments through the phone or the website.
- The service had developed an innovative mobile phone application. This application 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 application. This enabled women to have instant access to their scan images.
- The service had a range of packages with different price options and all packages included a wellbeing scan. Costs and payment options were clearly explained on the website, in information at the clinic and by staff when women attended.

Meeting people's individual needs

- The service took account of women's individual needs and delivered care in a way that met these needs.
- Women received written information to read and sign prior to their scan appointment. Staff told us they could access this information in different languages through the service's website. We saw copies of documents and key information were available on the website and could be accessed in many world languages as well as 'read aloud' for women who were visually impaired or who could not read. The service had a policy on the provision of key information which told staff the steps they should take to provide key information to women who had sight or hearing impairments.
- At the time of our inspection, there was no translation service for staff to use during an appointment with a non-English speaking woman. However, managers told us Window to the Womb Ltd was developing a mobile phone application to use in these circumstances that would be available to all clinics. Staff we spoke with told us they would ensure women received translated written information and copies of forms from the service's website if they did not speak English.
- The service had separate sessions for Window to the Womb scans and Firstscan early pregnancy scans. They changed the clinic before First scan sessions and removed all soft toys and keepsake items. Staff told us this was to be sensitive to the needs of women and families who might require more reassurance or have complications with their pregnancy. This also meant that women who may have experienced miscarriage did not share the same area with women who were much later in pregnancy.

Good

Diagnostic imaging

- 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.
- Women could buy a range of baby keepsakes and souvenirs after their scan. This included heartbeat bears, photo frames, fridge magnets and gender reveal products such as balloons. Heartbeat bears contained a recording of the unborn baby's heartbeat.

Access and flow

- People could access the service when they needed it. The clinic opened on evenings and weekends and there was a range of daytime, evening and weekend appointment times. Women could book appointments at a time to suit them.
- All women self-referred to the service. They could book an appointment in person, by telephone or using an online booking form on the website.
- At the time of our inspection, there was no waiting list or back log for appointments. Between January and December 2018, the service performed 3,022 scans, of which 524 were early pregnancy scans.
- Managers explained the booking system was flexible and allowed change to packages to meet women's choices. Women paid a small deposit and were given written information on what was and was not covered in their scan package. Women could change the package when they attended for their scan appointment if they wished.
- From January to December 2018 the service did not delay or cancel any ultrasound scans for non-clinical reasons.

Learning from complaints and concerns

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- The clinic reported all complaints received to Window to the Womb Ltd.
- The clinic had a complaints folder which staff could access. It contained an up-to-date complaints handling policy which set out the complaints process and staff responsibilities. The policy stated that all complaints should be sent an acknowledgement letter within three days and findings reported within 21 working days. Information on how to make a complaint was displayed throughout the clinic and on feedback cards for women.
- The service reported it had received four complaints between January and December 2018 of which one was upheld.
- We reviewed all four complaints made in 2018. We saw all were resolved within the time limit set out in the complaints policy. One complaint was progressed to a full investigation. The investigation was thorough and as part of it, the scan was peer reviewed by another sonographer and reviewed by the lead clinician. We saw complaints were dealt with sensitively. All women received a written response to their complaint which offered an apology, and in one case condolences, even when the complaint had not been upheld.
- We saw the service acted on learning from complaints. For example, staff had received additional gender identification training following a complaint about misidentification of gender. This had happened even though the complaint was not upheld.
- Following one complaint we saw evidence that learning had been discussed with the sonographer and followed up through observation of practice.

Are diagnostic imaging services well-led?

Good

We have not previously rated well-led. We rated it as **good.**

Leadership

- Managers at all levels had the right skills, experience and abilities to run a sustainable service.
- The registered manager attended a national franchise meeting every six months to share knowledge and experience. The registered manager received ongoing

training at these meetings. They also received additional training through site visits from the franchisor and monthly managers meetings. We saw positive working relationships between managers of the clinic, 1st Glimpse Ltd and support organisations.

- Managers had an awareness of the service's performance and challenges it faced. They could describe actions to address these challenges.
- Staff could access clinical leadership from three clinical leads. 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.
- Staff we spoke with told us that leaders were visible and approachable, and they felt well supported.

Vision and strategy

- Window to the Womb had a vision and strategy for what it wanted to achieve and the clinic had a clear business plan to turn this into action.
- Managers of Window to the Womb could tell us the vision for future service development across the organisation. The vision linked to the local business plan for the clinic. Business plans and progression were shared between support organisations and the service.
- The service had clear values of honesty, value and loyalty which underpinned the vision. Staff worked within these values and told us they tried to provide a positive customer experience.

Culture

- All managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- All staff we spoke with were proud of working for the service and spoke positively about the culture of the service. Staff told us they worked together well as a team and there was an open and honest culture. We saw a 'no blame' approach to the investigation of complaints and performance issues were addressed through open and honest feedback to staff.
- The service had a freedom to raise a concern policy and could contact a freedom to speak up guardian.The freedom to speak up guardian ensured staff could speak up and were supported appropriately if they had concerns regarding patient care. Staff received information on the role of the guardian and how to contact them in mandatory training, induction and a poster displayed in the staff kitchen.
- The service also provided a confidential telephone helpline for staff to contact if they wanted to discuss anything that affected them at work or if they needed emotional support.
- Throughout our inspection, managers responded positively to feedback and asked about improvements that could be made. 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.

Governance

- The service systematically improved service quality through regular audits and clinical reviews by lead clinicians. Governance arrangements were clear and appropriate to the size of the service.
- All staff were covered by the franchisor's indemnity and medical liability insurance, which was in date until October 2019.
- The service 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 registered manager had overall responsibility for clinical governance and quality monitoring and reporting this to 1st Glimpse Ltd and the franchisor. 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.

Good

Diagnostic imaging

- The service had robust policies and procedures for the operation of the service and these were available to staff in a folder in the clinic. All policies were up-to-date and reviewed annually.
- There was an audit programme in place which included monthly local audits, annual audits and peer review audits. Annual compliance audits included premises checks, health and safety, emergency planning, accuracy and completion of scan reports, completion of pre-scan questionnaires, professional registration and staff records. We saw clear actions were identified and agreed with the clinic.
- Staff discussed audit results, complaints, incidents, service changes and patient feedback at monthly team meetings.

Managing risks, issues and performance

- The service had systems to identify risks and plan to reduce them. The service completed risk assessments for identified risks. We saw up-to-date risk assessments were completed for fire, health and safety, legionnaires' disease and the Control of Substances Hazardous to Health. Risk assessments were recorded on a form which identified the risk and control measures and the member of staff responsible for monitoring and managing the risk. We saw that risk assessments were easily accessible to all staff and all staff had seen them.
- The service had appropriate emergency action plans in place in event of incidents such as power loss or fire. These outlined clear actions staff were to take and contact details of relevant individuals or services.
- The registered manager compiled a monthly performance report. Performance against key performance indicators was shared with staff in the monthly team meeting.

Managing information

- The service managed and used information to support its activities, using secure electronic systems with security safeguards.
- The service 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.
- The service had appropriate and up-to-date policies for managing women's personal information that were in line with relevant legislation and the requirements of the General Data Protection Regulations.
- The electronic booking system and customer database were maintained on a secure internet based server. Paper records and scan reports were stored securely and readily accessible to staff. All electronic systems were password protected. The clinic sent paper records over one month old to secure central storage.
- Staff recorded scans electronically and kept them for one month to enable peer review. After one month the recording was deleted.

Engagement

- The service engaged well with women, staff and the public to plan and manage appropriate services and collaborated with partner organisations well.
- The service gathered feedback from women and families and used this to improve the service. Women could leave feedback on comments cards, online review sites and social media pages. Comment cards asked women to rate their experience and we saw all women had rated their experience as 'five stars'. The website included details on how women could leave feedback. The website also showed stories of women's experience of using the service and their pregnancy.
- Feedback from women was shared and discussed at the monthly team meeting and any actions for improvement agreed.
- Staff received a monthly group wide 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 copies were kept in the communication folder in the staff kitchen.

Good

Diagnostic imaging

- Team meetings were held monthly with a formal agenda, with standing agenda items such as feedback, compliance and staffing. Minutes were shared with all staff in the communication folder. We reviewed minutes from September 2018 to January 2019 and saw they covered all agenda items and actions were identified and allocated to staff.

Learning, continuous improvement and innovation

- The service was committed to improving services by learning from when things went well or wrong and promoting training.
- We saw staff had participated in internal investigations following complaints and the service had provided additional training for staff when learning needs were identified through this process. For example, staff had attended gender identification training following a concern raised meaning learning from the concern was shared between all staff at the clinic.
- The service encouraged managers and staff to share their ideas and experience.They set up a confidential social media page for all managers and owners to do this.
- Staff took time together in team meetings and biannual national franchise meetings to review the service's performance and objectives. The service used the '30 second ideas' model to encourage all staff to quickly share ideas for improvement and learning on the social media page and in team meetings.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The service should assure itself that all staff can identify the underlying reasons women may present for multiple scans and be able to provide appropriate support to such women.
- The service should consider providing access to translation services for women and staff to use during scan appointments.