

ANA Services Ltd

Window to the Womb

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Inspected but not rated 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

Overall summary

The service did not have a previous rating. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	The service did not have a previous rating. We rated it as good.



Summary of findings

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Summary of this inspection

Background to Window to the Womb

Window to the Womb is operated by ANA Services Ltd and operates under a franchise agreement with Window to the Womb (Franchise) Ltd. The service provides a diagnostic imaging service (ultrasound scans) to self-funding pregnant women aged 16 and above.

Window to the Womb has separated their services into two clinics: the 'First-scan' clinic, which specialises in early pregnancy scans and a 'Window to the Womb' clinic which offers later pregnancy and wellbeing scans (Window scans).

Activity (January 2021 – October 2021):

- First Scans (6-15 weeks): 1,113 scans
- Wellbeing and gender (16 weeks plus): 1,917 scans
- 4D scans (24-34 weeks): 784 scans
- Growth and presentation scans (26 weeks plus): 70 scans

Track record on safety:

The service had no never events, serious incidents or clinical incidents reported since January 2021. The service provides diagnostic pregnancy ultrasound services to self-funding women. All scans carried out include wellbeing as the primary purpose.

The registered manager has been in post since March 2021.

How we carried out this inspection

During our inspection we visited the reception area, the scanning, printing, quiet and storage rooms. We spoke with four members of staff including the clinic manager, registered manager, scan assistant and a sonographer. During our inspection, we reviewed 10 sets of patient records. We also reviewed policies and procedures and other documents.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the services first inspection since registration with the CQC in 2015. The service employed one full time sonographer and six scan assistants.

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

Areas for improvement

Action the service SHOULD take to improve:

Summary of this inspection

The service should ensure that staff are bare below the elbows in clinical areas.






Our findings

Overview of ratings

Our ratings for this location are:

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

Diagnostic imaging

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

Are Diagnostic imaging safe?

Good 

The service did not have a previous rating. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. Staff at the service had all completed mandatory training and records showed 100% completion.

The mandatory training was comprehensive and met the needs of patients and staff. Staff completed training on recognising and responding to patients with mental health needs. Managers monitored training and sent reminders to staff if they were approaching training deadlines.

Managers held monthly refreshers on specific aspects of mandatory training. The past three topics were the Mental Capacity Act, fire safety and safeguarding children.

New staff had to complete all mandatory training before they started work and were given a two-week period to do this alongside other induction activities.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. The registered manager was level three trained in both adult and children's safeguarding. Sonographers and scan assistants had trained to level two in both adult and children's safeguarding. There was a completion rate of 100% for all staff groups.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff showed a good knowledge of safeguarding and described a recent incident where staff raised a safeguarding alert. Leaders shared learning from safeguarding from other locations via training, staff newsletters and staff meetings.

Diagnostic imaging

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had access to a safeguarding policy which referenced local authority leads and contact details for the franchise lead for safeguarding. Leaders reviewed this annually to ensure it was up to date.

Staff followed safe procedures for children visiting the service.

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Managers monitored cleaning records and undertook spot checks to highlight any areas of concern.

Cleaning records were up-to-date and showed all areas were cleaned regularly. Staff had completed checks fully in the two weeks prior to inspection. Staff did a two-weekly deep clean following a cleaning checklist.

Staff cleaned equipment after patient contact. Staff kept equipment clean between patients and used the correct cleaning products to ensure cleaning was effective. Transvaginal probes were cleaned using a nationally recognised cleaning system. All staff, including the scan assistants, had received training on the cleaning of transvaginal probes. Managers said this allowed them to question sonographers if they felt they were not using the correct technique and showed a proactive and open safety culture.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff wore correct PPE. Staff had received training on additional infection prevention and control measures because of the COVID-19 pandemic.

The service provided a portable handwashing sink in the scan room and staff washed their hands in line with national guidance. Staff followed national guidance and did not wear jewellery or watches.

However, although staff wore scrubs in the clinical room, the scrubs had a full sleeve and therefore meant staff were not bare below the elbow in line with national guidance.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. The unit layout ensured privacy. Patients had a comfortable waiting area and a quiet area should women and their families need it.

Staff carried out daily safety checks of specialist equipment. There was a service level agreement for the maintenance of equipment. An external company carried out annual checks on specialist equipment. Staff could contact the external company who responded quickly if any issues occurred. The service had not had to cancel any appointment due to faulty equipment in the past year.

The service had enough suitable equipment to help them to safely care for patients. Stock items were all within the expiry date and stored safely. The unit could request stock from other locations within Window to the Womb in emergencies. Managers reported this rarely happened but they found it was reassuring to have the option.

Diagnostic imaging

Staff disposed of clinical waste safely. The service stored clinical waste correctly and an external company collected it regularly. Waste bins located outside the unit were locked and secure.

The service stored control of substances hazardous to health (COSHH) securely in a locked cupboard and completed risk assessments for all chemicals used.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Women completed a risk assessment/questionnaire at the time of booking. Staff reviewed this when women arrived for their scan. Women had the chance to complete this on site if they had not done so before arrival.

There was a clear process to escalate unexpected or significant findings. The Window to the Womb franchise employed two sonographer clinical leads who were available to review scans remotely whilst the woman was still at the clinic. Sonographers could contact clinical leads if they required a second opinion of the scan. Clinical leads usually responded within 20 minutes.

Staff completed referrals on a dedicated referral form. Staff shared key information to keep women safe when handing over their care to others. The clinic manager stored referrals securely and monitored how many referrals there were each month.

Staff would not scan a woman within two weeks of a previous scan. Staff asked women when they arrived when their last scan was and advised of the risks of frequent scanning.

Women signed a self-declaration stating they were receiving or intended to receive maternity care through the NHS. The service asked women to bring their NHS maternity medical record with them when they came to the clinic. This was to help assure the service that the woman was on an NHS maternity pathway. Staff advised women to continue with their NHS scans as part of the maternity pathway.

Staff would call 999 in any emergency. Staff rang also 999 if they detected an ectopic pregnancy. Staff kept woman in the scanning room on the scanning couch until emergency support arrived.

The service provided women with a leaflet about when they should contact their maternity unit. This included swelling of hands face or feet, vaginal bleeding, reduction in fetal movement, persistent headache, or a high temperature. Staff provided women with contact details of local hospitals in an information pack.

The service did not require a resuscitation trolley. The service had a first aid box stored in the staff room which was within the expiry date. Staff were up to date with adult and children's first aid training.

Staffing

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

The service had enough staff to keep patients safe. Managers accurately calculated and reviewed staffing numbers and scan appointments and adjusted the number of staff needed for each shift.

Diagnostic imaging

The service operated with a qualified sonographer, clinic manager and scan assistants. For most clinics, there were two scan assistants plus a sonographer routinely rostered. A scan assistant acted as a chaperone for all women alongside the sonographer while in the scan room.

The service had one vacancy advertised currently. Managers accessed staff from across the nine ANA Services Ltd locations if they were short staffed, for example, during annual leave or sickness. All clinics had the same equipment, policies, process and systems to make the transition between locations safer and easier.

Records

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

Patient records were comprehensive and all staff could access them easily. Staff had sufficient information from women before scans were taken. This included allergies, pregnancies, and information on the woman's menstrual cycle.

Women transferred between services had their referral information with them. The service stored records online and staff kept paper copies in a folder for ease of access. Staff reported there were no delays in accessing women's records. Sonographers signed all referrals which contained all the information needed for transfer between services.

Staff stored records securely. Staff locked patient information and records in a locked filing cabinet behind the reception desk. Managers and scan assistants had different levels of password protected access to online records depending on need.

The service stored older records off site. The scanning machine stored ultrasound images which were password protected.

Women completed a self-declaration which gave consent for staff to share clinical information with their NHS service, if needed.

Medicines

There were no medicines held at this location.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff recorded all incidents in a log book and completed an accident record if appropriate. Staff raised concerns and reported incidents and near misses in line with provider policy.

Managers shared learning from incidents with all staff and used monthly staff meetings to provide feedback to all staff.

Managers shared learning about incidents that occurred at different locations in the franchise. Recent examples included guidance on how to ensure women were receiving NHS maternity care.

Diagnostic imaging

Staff were aware how to report serious incidents and in line with provider policy. The service had no never events or serious incidents.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. The policy was accessible to staff and formed part of mandatory training and induction.

Managers debriefed and supported staff after any serious incident. Managers offered staff a debrief following a recent difficult situation. Managers supported staff and recognised the effect that incidents could have on them.

The provider cascaded any patient safety alerts and implemented changes. The service was reviewing single use ultrasound gel as a result of a recent alert.

Are Diagnostic imaging effective?

Inspected but not rated 

We do not currently rate effective for diagnostic imaging.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The franchise reviewed and updated policies. Managers ensured staff knew about changes via emails or in daily briefings and monthly team meetings.

Managers monitored staff to ensure they were following policy and procedures. Staff had regular 'care and service assessments' which ensured staff were following guidance in many aspects of their jobs, including how they interacted with patients and if they followed correct infection prevention and control measures.

The service reviewed policies annually and they indicated when they next needed a review.

Staff had mental capacity act training and recently had a follow up session as part of the monthly additional refresher training.

Nutrition and hydration

Women had access to water, tea or coffee if required.

Pain relief

Staff assessed and monitored patients to see if they were in pain.

Staff did not offer women pain relief due to the nature of the service. However, sonographers ensured that women were comfortable throughout their scan.

Diagnostic imaging

Patient outcomes

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

Managers and staff used the results to improve patients' outcomes. Lead sonographers regularly reviewed scans to check for quality and diagnosis.

Sonographers had access to clinical leads for advice and reviews. Sonographers also attended monthly meetings with their peers to discuss cases and share learning.

Managers and staff carried out a programme of repeated audits to check compliance with expected standards. Audits included equipment, infection control, care assessments and patient records. Audit tools contained a free text box to record any adverse results and these were to be actioned before the next audit and recorded if they were completed. Managers shared, and made sure staff understood, information from the audits and checked for improvement.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All staff undertook continuous professional development and training was "considered part of the day job". Staff had specific training on chaperoning and supporting women after unexpected results from scans.

Sonographers were all Health and Care Professions Council (HCPC) registered.

Managers gave all new staff a full induction tailored to their role before they started work. The induction included location specific information as well as information about the provider.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff had annual appraisals and these were all up-to-date. Managers also supported staff to develop through regular, constructive clinical supervision of their work. The care and service assessments formed part of this supervision.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Meetings followed a set agenda and updated staff about any feedback, news or actions they needed to take.

There was a policy in relation to poor staff performance. The manager had not had to implement it to date said they would deal with any issues promptly and support staff to improve.

Multidisciplinary working

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

The team worked well together and communicated well with each other. The registered manager worked closely with the clinic manager and there was a good relationship between all staff at the unit.

Staff had good links with local NHS early pregnancy units. They were able to access these clinics on women's behalf if they needed urgent referral.

Diagnostic imaging

Sonographers had access to a lead who would discuss cases with them and review their scans. They worked together well to ensure learning was shared openly and with sonographers at other Window to the Womb locations.

Seven-day services

The service ran on demand.

Currently the service ran on Wednesday, Friday, Saturday and Sunday with varied opening times depending on demand.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. The service provided leaflets that contained information for women and their families. This included eating well, stopping smoking, alcohol avoidance and foods to avoid.

The Window to the Womb website also had information on scan frequency and links to blogs with information about leading healthier lifestyles.

Leaflets also recommended what information was best for the women to ask their midwife about. This included, discussing birth plans and what breast-feeding services were available.

The service offered women help and advice through an online midwifery service which was advertised on the information women were given.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were aware of the Mental Capacity Act and its application although they could not recall a time when they had a concern about a woman's capacity.

Women received written information to read and sign before their scan. This included information about ultrasound scanning and safety information, a pre-scan questionnaire and declaration form which included terms and conditions.

The service gave women additional information for early pregnancy scans that told them more about the scan and information should the sonographer need to perform a transvaginal scan due to the early stage of the pregnancy.

Staff gained consent before scanning women. Women were asked to sign a consent form which detailed the scan, any risks and unexpected outcomes. Staff clearly recorded consent in the patients' records. The sonographer explained the scan to women and obtained verbal consent before commencing scanning.

Staff understood Gillick Competence and Fraser Guidelines and supported children aged 16 or over who wished to make decisions about their treatment. The service had a policy available to staff. Staff completed additional checks on under 18s including asking for identification to verify a women's age. The service required under 18s to have a parent or guardian with them at the scan.

Diagnostic imaging

Are Diagnostic imaging caring?

Good 

The service did not have a previous rating. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff were friendly and spent time with women to ensure they were comfortable.

Patients said staff treated them well and with kindness. Women reported feeling well looked after and were happy with the service they received.

Staff followed policy to keep patient care and treatment confidential. There were separate areas including a quiet room to ensure women had privacy before and after their scans.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff held discussions in a respectful manner with showed compassion for women's circumstances.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff recently considered a women's cultural needs and made adjustments to staffing because of this.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff were able to support women following bad news. Staff could help women to book appointments at the local NHS hospital if needed and signposted them to support networks.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. If women became distressed staff were able to extend appointments or move women to a separate room to ensure they did not feel pressured to leave.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The service gave staff additional training on supporting women after unexpected news. Staff gave women Information leaflets post-scan which had information on the diagnosis and what to expect after they have left the unit.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff demonstrated compassion and understanding when talking about the service users and their families.

Diagnostic imaging

Staff referred patients for mental health assessments when they showed signs of mental ill health, such as depression. The service had links with a counselling service and signposted women to this if needed.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff gave women opportunities at booking, on arrival and in the scan room to ask questions about the scan.

Staff talked with patients, families and carers in a way they could understand. Staff made sure women understood the procedure and had access to communication aids where necessary. Staff also gave women details of who to contact should they have any further questions after they had left.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff gave women information on how to feedback about the care they had received.

Patients gave positive feedback about the service via an online feedback platform. Managers were hoping to reintroduce paper feedback cards soon. The service had suspended these due to the COVID-19 pandemic.

Are Diagnostic imaging responsive?

The service did not have a previous rating. We rated it as good.

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the changing needs of the local population. The service had recently moved location as the old location did not offer enough privacy to women.

Women could book evening and weekend appointments. Managers had recently introduced a Sunday clinic as they recognised an increased demand for weekend services.

Facilities and premises were appropriate for the services being delivered. The new location had enough space to offer women a waiting area and room to view their images as well as a quiet room separate to the scan room.

Managers monitored and took action to minimise missed appointments. The service sent women were reminders prior to their appointment. There were no missed appointments in the past three months.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Diagnostic imaging

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The policy outlined how staff could help women with additional needs. There was a lead within the Window to the Womb franchise that staff could contact if they had any questions. Staff had recently supported a woman who had autism through the scan process.

The service had information leaflets available in languages spoken by the patients and local community. Staff identified women that may need assistance at the point of booking and additional measures were put in place. The service had access to a telephone interpreting service.

Staff could access a “read aloud” online service for women with visual impairment.

The service was not accessible to wheelchair users as it was located on the first floor. The service made sure users were aware of this during the booking process. Women were signposted on the website or via the telephone to other Window to the Womb locations close by that were accessible.

Access and flow

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

Managers monitored waiting times and made sure women could access services. If there was not an appointment to suit the woman at the Bagshot location then the service arranged a scan at a different branch.

Women could book online or by telephone and a range of appointment times were available. Staff were able to book last minute appointments as they held two slots a day for unexpected bookings

Managers rearranged appointments as soon as possible and a full explanation given in the event of any cancellation. There had been no cancelled appointments in the past three months.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The service provided information on how to make a complaint in information women received post-scan.

The service clearly displayed information about how to raise a concern in patient areas. The service had information displayed on a notice board in the reception area which gave details of the complaints process.

Staff understood the policy on complaints and knew how to handle them. Staff had to sign to say they had read the complaints policy. Managers held discussions on complaints during staff meetings and gave feedback at the time if staff members were involved in a complaint.

Managers investigated complaints and identified themes. The clinic manager monitored all feedback and would follow up on any negative reviews to try and resolve them.

Diagnostic imaging

Other staff members knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. There had been three formal complaints logged in the past year. Managers shared feedback from these complaints with staff members involved and recorded this in meeting minutes.

Are Diagnostic imaging well-led?

Good 

The service did not have a previous rating. We rated it as good.

Leadership

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

The clinic manager ran the service day to day with the support of the registered manager. The regional manager had responsibility for the clinics operated by the franchisee.

Staff told us the registered manager was approachable and were happy to go to them with any concerns or queries. The registered manager was available by telephone when they were not on site.

The registered manager told us that the regional manager and franchisee were very supportive, and they could contact them any time for help and advice.

The Window to the Womb Ltd franchisor delivered ongoing training to registered managers. This included clinic visits and training events. A twice-yearly national franchise meeting had been suspended during the COVID-19 pandemic. This had recently been re started with the first event held in October 2021.

Registered managers in the franchise attended monthly meetings. Meetings involved training and shared learning. The clinic manager reported that the registered managers in the group worked well together and supported each other.

The franchisor provided leadership and support and all the staff we spoke with told us that they were approachable and responsive when they contacted them.

Staff could access clinical leadership from clinical leads employed by the franchisor. The clinical leads assessed all new sonographers and were available to offer clinical advice when needed, they also offered supervision training annually.

Vision and Strategy

The service had a vision for what it wanted to achieve.

The service had identified values which underpinned their vision. The service values included focus, dignity, integrity, privacy, diversity staff and safety.

During our inspection we saw that staff worked in line with the services values. Staff we spoke to were committed to providing a high-quality service to all women who used it.

Diagnostic imaging

Culture

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

The service promoted an open and honest culture. The franchise had a freedom to raise a concern policy in place and had a 'freedom to speak up guardian'.

The registered manager understood the duty of candour. There was a policy which staff signed to say they had read. Staff were able to give us examples when they would implement the duty of candour.

Staff were proud to work for the service and invested in the service they delivered. We observed a very caring culture with staff demonstrating a caring approach to service users and each other.

The culture was inclusive, and staff treated all service users equally. There was an equality policy which included sexual orientation, disability, age, race and religion. Reviews left by women mentioned feeling safe, supported and not judged.

Governance

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

The service had a clear governance policy. This outlined the responsibility of board members, the relationship between the 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 the franchisee and the franchisor. This included investigating incidents and responding to patient complaints.

The regional manager and franchisor supported the registered manager. Franchise meetings discussed clinic compliance, performance, audit and best practice.

There was an audit programme 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.

The franchisor held monthly manager meetings attended by senior staff across the franchise group. Managers discussed and documented performance, complaints, compliments, training and compliance with policies and procedures. There was an action plan for issues discussed and a completion date.

All staff attended monthly local team meetings at the clinic. Staff discussed compliance with policies and procedures, audit results, complaints, incidents and patient feedback.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Diagnostic imaging

Managers completed risk assessments and updated them as needed. Risk assessments were in place for fire safety, legionnaires' disease, infection control, health and safety and the Control of Substances Hazardous to Health (COSHH).

The registered manager recorded risk assessments on a form which identified the risk and control measures. Risk assessments were easily accessible to all staff.

The service did not have a risk register in place. However, the regional manager and registered manager reviewed all risk assessments and documented any changes or identified new risks.

The service had a clinic contingency plan to identify actions to be taken in the event of an incident that would impact the service, for example, extended power loss, severe weather events, short notice staff sickness and equipment failure. The contingency plan included contact details of relevant individuals or services for staff to contact.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure

Staff stored paper, electronic records and scan reports securely. The service retained records in line with General Data Protection Regulations (GDPR).

The service stored electronic records securely and these were password protected. The service had an information governance policy and all staff had completed mandatory information governance training.

Managers monitored key performance indicators and used these to make improvements. Sonographers had the quality of their scans reviewed and managers used these reviews to provide additional, targeted training.

A number of metrics were considered at monthly team, managers and regional meetings to ensure consistency across the region. This included complaints, feedback from women, audit results, and re-scan figures.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Women could leave reviews on the services website and through social media sites. The service suspended paper-based feedback following national guidance during the COVID-19 pandemic.

The service had established good links with local NHS trusts. Staff told us they liaised with NHS trusts when women needed a referral following an unexpected scan result. Staff contacted the trust directly and ensured that the woman had an appointment to see the relevant team.

Managers kept staff informed and staff felt involved in the running of business. Managers shared information with staff informally daily and formally via monthly team meetings. Staff also received information via email.

The franchise produced a newsletter to share information with staff members. This included information on staffing, updates to the service, any changes and announcements. Staff had to sign to indicate they had read the newsletter.

Diagnostic imaging

The clinic had established a working relationship with the Miscarriage Association. There were cards that staff could pass on to women with information about how they could access support.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

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Window to the Womb had developed a mobile phone application called 'Bumpies.' The application allowed women to document and share images of their pregnancy. Women could share scan images with friends and family if they wished. It was optional for women to use. The service was about to introduce a personal video message that women can access after an unexpected result following any scans. This aimed to provide a more personal approach and staff felt this was better than just sending women home with a leaflet.