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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Window to the Womb is operated by 1st Glimpse Limited, and operates under a franchise agreement with Window to the Womb (Franchise) Ltd. The service provides diagnostic pregnancy ultrasound services to self-funding pregnant women over the age of 18.

We inspected diagnostic imaging facilities.

We inspected this service using our comprehensive inspection methodology. We carried out a short notice inspection on 9 January 2019. We gave staff two working days' notice that we were coming to inspect to ensure the availability of the manager and clinics.

To get to the heart of women's experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

The main service provided by this unit was ultrasound scanning.

Services we rate

This was the first inspection of this service. We rated it as **Good** overall.

We found good practice in relation to diagnostic imaging:

- There were sufficient numbers of staff with the necessary skills, experience and qualifications to meet women's needs.
- There was a programme of mandatory training which all staff completed, and systems for checking staff competencies.
- Equipment was maintained and serviced appropriately and the environment was visibly clean.
- Records were up to date and complete and kept protected from unauthorised access.
- The service had implemented a programme of audits relating to patient outcomes
- Staff demonstrated a kind and caring approach to the women using the service and supported their emotional needs.
- Appointments were available during the evening, at weekends and at short notice if required.
- The service had supportive and competent managers. Staff understood the vision and values of the organisation.

However:

- The service had not completed a hand washing audit.
- The service did not record how lessons learnt from incidents were shared.
- The service did not have a registered manager in place.

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

Summary of findings

Dr Nigel Acheson

Deputy Chief inspector of Hospitals (London and the South East)

Overall summary

Window to the Womb was located at 39 Wood Street, Walthamstow, London. The service had a large reception area, a scan room, quiet room, toilet, and staff room. The service used its other rooms for storage and record keeping.

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

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

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

The Window to the Womb clinic sees approximately 70 women per week and offers the following scans:

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

Window to the Womb was registered to provide the following regulated activities:

- Diagnostic and screening procedures

During the inspection we spoke with staff including; the manager, scan assistants, regional manager and director.

We gathered views from four women and reviewed feedback women had provided the service on social media. During our inspection we reviewed 10 patient records.

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

Staff in the service consisted of one whole time equivalent (WTE) manager, a sonographer and four scan assistants, on each shift the service operated with a team leader/manager a sonographer and two scan assistants.

Track record on safety

- No never events.
- No serious injuries.
- No incidences of healthcare acquired Meticillin-resistant Staphylococcus aureus (MRSA).
- No incidences of healthcare acquired Meticillin-sensitive staphylococcus aureus (MSSA).
- No incidences of healthcare acquired Clostridium difficile (c. diff).
- No incidences of healthcare acquired Escherichia coli (E-Coli).
- No deaths.

Services provided under service level agreement:

- Clinical and or non-clinical waste removal
- Building Maintenance and services
- Ultrasound machine maintenance

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	The provision of ultrasound scanning services, which is classified under the diagnostic core service, was the only core service provided at Window to the Womb. We rated the service as good overall because it was safe, caring, responsive and well-led. Feedback from women and their families was positive. Women could access services and appointments in a way and at a time that suited them, technology was used innovatively to ensure women had timely access to treatment, and the registered manager had the appropriate skills and experience to manage the business.

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

This report relates to diagnostic imaging services provided by Window to the Womb.

1st Glimpse Limited operating as Window to the Womb (Walthamstow) opened in 2014 with an aim to provide diagnostic imaging services to pregnant women on Mondays, Wednesdays and Fridays 4pm to 8pm and all day at weekends. The service has introduced early pregnancy scans to provide services to pregnant women from six weeks onwards.

1st Glimpse Limited is a private company operating under the Windows to the Womb under a franchise agreement with Window to the Womb (Franchise) Ltd. Window to the Womb (Franchise) Ltd was established in 2003 and now has 36 franchised clinics across the United Kingdom.

As part of the agreement, the franchisor (Window to the Womb Ltd) provides the service with regular on-site support, access to their guidelines and policies, training, and the use of their business model and brand.

The service provides ultrasound examinations privately to women from the local area.

The service does not currently have a manager in post registered with the CQC although the current manager had recently begun the process of registration with the CQC. We inspected this service on 9 January 2019. This was the first inspection since registration.

Our inspection team

The team that inspected the service comprised a CQC lead inspector. The inspection was overseen by Terri Salt Head of Hospital Inspection.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **Good** because:

- The service had systems in place to ensure staff had received mandatory training in key skills and made sure that everyone had completed it.
- Staff were knowledgeable about safeguarding processes and what constituted abuse.
- Each patient had a referral form and we saw that any risks were
- identified or documented.
- All staff demonstrated an understanding of the duty of candour and the principles behind this.
- Equipment was serviced and there were processes to ensure all items were well maintained.

However

- The service had not conducted a hand hygiene audit.
- The service did not routinely document how learning from incidents had been shared.

Are services effective?

Not sufficient evidence to rate

We do not currently rate effective for diagnostic imaging.

- Policies, procedures and guidelines were up to date and based on National Institute for Health and Care Excellence (NICE) guidelines, relevant regulations and legislation.
- Staff worked collaboratively as part of a multi-professional team to meet women' needs.
- There were systems to show whether staff were competent to undertake their jobs and to develop their skills or to manage under-performance.
- There was effective multidisciplinary team working throughout the unit and with other providers.
- Information provided by the unit demonstrated 100% of staff had been appraised.

Are services caring?

Good

We rated caring as **Good** because:

- Women were treated with kindness, dignity and respect. This was reflected in feedback we received from women.

Summary of this inspection

- Women received information in a way which they understood and felt involved in their care. Women were always given the opportunity to ask staff questions, and women felt comfortable doing so.
- Staff provided women and those close to them with emotional support; staff were supportive of anxious or distressed women

Are services responsive?

Good

We rated responsive as **Good** because:

- The service offered a number scans for pregnant women such as, well-being, viability, growth and presentation, gender together with the ability for digital images.
- Patient complaints and concerns were managed according to the services policy.
- The service provided evening and weekend appointments to meet the requirements of women.

Are services well-led?

Good

We rated well-led as **Good** because:

- Staff said managers were visible and approachable. Staff informed us they felt supported by the management team.
- There was a clear governance structure, which all members of staff were aware of.
- The clinic had its own risk register and the manager had clear visibility of the risks and was knowledgeable about actions to mitigate risks.
- There was a culture of openness and honesty supported by a whistle blowing policy.

However

- At the time of the inspection the service did not have a registered manager in place.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Diagnostic imaging

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

Are diagnostic imaging services safe?

Good

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

Mandatory training

- **The service had systems in place to ensure staff had received mandatory training in key skills and made sure that everyone had completed it.**
- Annual mandatory training courses were undertaken and regularly updated, training was provided either face to face, online or by means of webinars. The service provided us with its training matrix which showed staff received mandatory training in; fire safety and evacuation, health and safety in healthcare, equality and diversity, infection prevention and control, safeguarding adults, customer care and complaints, basic life support (BLS) and data security awareness.
- Mandatory training rates were reviewed yearly. At the time of this inspection records we viewed demonstrated 100% of staff had completed mandatory training. The service had a rolling monthly programme of mandatory training which meant that every month staff would receive training in a different aspect of their mandatory training.

Safeguarding

- **Staff understood how to protect women from abuse. Staff had some training on how to recognise and report abuse and knew how to apply it.**
- The lead for adults and children's safeguarding was the manager who was also supported by a regional manager.
- Staff were trained to recognise adults and young people at risk and were supported by the Window to the Womb safeguarding adults' and children's policy, staff received training in adults and children's safeguarding during induction to the service.
- The provider had a safety and safeguarding policy which was in place. The provider had an adult and child safeguarding policy that staff were familiar with and had access to it on the intranet.
- Safeguarding policies were up to date and reviewed regularly. They clearly outlined staff responsibilities and how they should raise a safeguarding concern as well as immediate action to be taken where concerns related to a child.
- Staff we spoke with demonstrated they understood their responsibilities and adhered to the company's safeguarding policies and procedures. The policies were clear, thorough and covered all types of abuse including female genital mutilation (FGM).
- 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff', March 2014 guidance. This states all non-clinical and clinical staff that have any contact with children, young people, parents or carers should be trained to level two safeguarding.

Good

Diagnostic imaging

- At the time of this inspection the manager of the service was trained to level three for both safeguarding adults and safeguarding children, other staff had recently received level two training this met intercollegiate guidance.
- Staff knew how to report a safeguarding concern but there were no safeguarding concerns raised from November 2017 to October 2018. We saw contact phone numbers for local authority adult and children's safeguarding teams were available for staff.
- Window to the Womb did not provide services for women under the age of 18 years.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff kept equipment and the premises visibly clean. They used control measures to prevent the spread of infection.**
- The service had infection prevention and control (IPC) policies and procedures which provided staff with guidance on appropriate IPC practice in for example, communicable diseases and isolation.
- During this inspection we saw all areas of the service were visibly clean. An external cleaning company cleaned the scanning room each day according to the services cleaning manual and room specifications document. This was recorded on a daily check spreadsheet and was reviewed by the clinic manager each week.
- Staff followed manufacturers' instructions and the Window to the Womb guidelines for routine disinfection. This included the cleaning of the medical devices between each patient and at the end of each day.
- Equipment and machines were cleaned following each use, this included such things as the transvaginal probe used for internal examinations. We saw that the service recorded the batch number and expiry date of the cleaning product used for cleaning the transvaginal probe.
- Couches were covered with a disposable paper towel which was changed following each scan.
- We reviewed all machines in use during this inspection, and saw where appropriate, disinfection of the machines had taken place and a weekly check of each machine was available.
- We found that the service ensured the safe storage of substances hazardous to health (COSHH) and other chemicals were stored in a locked cabinet.
- Between November 2017 and October 2018 there had been no incidences of health care acquired infection in the service.
- The clinic manager observed staff compliance towards hand hygiene, and infection prevention and control, the service had developed a hand hygine audit to measure staff compliance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene' although one had not been completed for the service.
- These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene to reduce risk of cross contamination between women. Staff had access to hand washing facilities and we saw hand washing instructions above each sink.
- Staff were bare below the elbow and had access to a supply of personal protective equipment (PPE), including gloves and aprons.
- Waste was handled and disposed of in a way that kept people safe. Waste was labelled appropriately and staff followed correct procedures to handle and sort different types of waste. The service had a contract in place for the removal of any clinical waste.

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 layout of the unit was compatible with health and building notification (HBN06) guidance. There was a large reception area with a reception desk that was staffed during opening hours. Within the reception area was a range of magazines, refreshments and toilet facilities for women and relatives.
- The service was located on the ground floor with no restrictions of access and was accessible to all women.

Good

Diagnostic imaging

- The provider's maintenance and use of their facilities kept people safe. Waiting areas were visibly clean and tidy throughout. The scanning room was spacious and well-lit and had a sign on the door to notify people when it was in use.

  The treatment room had a slave monitor so that patients, family or friends could see the scan images whilst the scan was taking place. A slave monitor in radioography is an additional screen where ultrasound images can be displayed live; for patient, friends and family.

- The service's ultrasound machine was maintained and regularly serviced by the manufacturers. We reviewed service records for the equipment, which detailed the maintenance history and service due dates of equipment. The service record for the machine confirmed it had been serviced annually, last completed in August 2018.

- The service had systems in place to ensure machines or equipment were repaired in a timely manner, when required, this ensured women would not experience prolonged delays to their care and treatment due to equipment being broken and out of use.

- Staff had sufficient space to move around the ultrasound machines for scans to be carried out safely and there were comfortable couches for women and stools for the operator.

- All equipment conformed to relevant safety standards non-medical portable appliance electrical equipment was tested.

- The service had a first aid kit available, when we checked this we found all the contents in date.

- We reviewed the local audits conducted by the manager along with the clinical governance audit conducted by the franchisor during 2018 concerning such things as the cleanliness of the environment and health and safety which found the service to be compliant in all areas.

Assessing and responding to patient risk

- **Staff reviewed and updated risk assessments for each women through individual referral forms.**

- Access to the service was through self-referral. Women completed a referral form, which included their personal details, pregnancy history, including any previous ectopic pregnancies and consent.

- The referral form included space for other notes to be added for the sonographer. If they had concerns, the sonographer followed the service's referral pathway and referred the woman to the most appropriate healthcare professional, with her consent.

- Staff were trained to ask women reasons for their attendance at the service. The service provided two options for women, the first was a 'first scan'. This was a scan available for women who were pregnant between seven and 15 weeks. Its primary purpose was to determine the viability of the pregnancy using ultrasound. The scan could also be used to date the pregnancy and determine whether it was a single or multiple pregnancy. The second option was for well-being scans with the option of 4D pictures.

- There were posters within the unit reminding staff to carry out identification checks. There was a pause and check process in place to prevent errors. This consisted of the three-point check to correctly identify the patient, this check included first name, last name and date of birth.

- Sonographers discussed the risks and benefits with women. The service kept a record of women they had signposted to the early pregnancy unit and informed franchisor, this was in line with the services fetal abnormalities policy.

- If the sonographers observed areas of a scan that could indicate concerns the service would refer the patient to their local hospital for further investigations and management. There was no service level agreement in place for this with local hospitals but the service documented all referrals it had made to early pregnancy units.

- The sonographers could contact a lead sonographer for advice and support during their clinics. The lead sonographer was employed by the franchisor and was available to review any ultrasound scan remotely within one to two hours.

- Following each scan, the sonographer provided the patient with a 'fetal well-being report.' The report

contained information about the pre-scan checks that had been conducted by the sonographer, such as 'Are you (the sonographer) satisfied that the service is appropriate for the service user and can therefore be offered to the service user?'

- The report also documented both fetal, placenta position checks and documented the fetal anatomy sweep (, including such things as fetus gender, limbs, restrictions of view and growth measurements. The report instructed that the report should be shared with the patient's midwife to ensure appropriate antenatal care.
- Medical emergency procedures were regularly audited. We viewed the unit's medical emergency audit dated October 2018. There were procedures for transfer of a collapsed patient. All clinical staff were basic life support (BLS) trained, the service only accepted women who were physically well. Staff told us if a patient required urgent treatment they would call 999. Should women arrive at the service in pain or bleeding then they would be signposted to the early pregnancy unit.

Staffing

- **The service had enough staff with the right qualifications and experience to provide the right care and treatment.**
- Tthe service ensured that there was a sonographer, manager and two scan assistants present during clinic hours. On average the service had 15 appointments each day booked throughout the day and sufficient staffing to manage appointments.
- The service did not use agency staff.
- We found that the sonographer employed by the service was registered with the Health and Care Professionals Council (HCPC) and the certificate of registration was displayed within the service.
- The manager was responsible for monitoring the hours worked by staff and ensuring they did not exceed working time limits. This included ensuring staff working longer than 6 hours at a time received a 20-minute rest break. Staff were entitled to a daily rest period of at least 11 hours uninterrupted rest in every 24-hour period, as well as a weekly rest period of 24 hours uninterrupted in every seven-day period. The clinic manager could adjust staffing numbers to meet demand.
- There were business continuity plans in place to ensure the service operated when their were changes to normal operating circumstances. For example, sickness, absenteeism and workforce changes.
- The service had a recruitment policy and procedure in place but this was not always followed we noted in one person's file that the service had not satisfied itself of the conduct of an employee who had previously worked in health and social care. The regional manager stated that this would be addressed.
- All staff we spoke with felt staffing was managed appropriately

Records

- **Staff kept detailed records of women's appointments, referrals to NHS services and completed scan consent documents. Records were clear, up-to-date, and easily accessible to staff providing ultrasound scans.**
- Women' personal data and information were kept secure. Only authorised staff had access to women' personal information.
- Staff training on information governance and records management was part of the mandatory training programme.
- The ultrasound images were saved onto a USB stick, which could be purchasedat the end of her appointment. They were also given free access to the 'Bumpies' mobile phone application ('app'), which had been developed by the franchisor. The Bumpies app enabled women to have instant access to their scan images.
- We reviewed 10 patient care records during this inspection and saw records were accurate, complete, legible and up to date. This included the woman's estimated due date, the type of ultrasound scan performed, the findings, conclusions, and recommendations. Reports of the scans were given to the patient directly.

Good

Diagnostic imaging

Medicines

- Medicines were not used at Window to the Womb, allergies were documented and checked on arrival at the service and were documented on the notes for the sonographer.

Incidents

- **Processes were in place for staff to raise concerns and report incidents. Staff understood their roles and responsibilities to raise concerns and record safety incidents. Lessons learned were shared with the whole team and the wider service.**
- The service had an incident reporting policy and procedure.. Staff understood their responsibilities to raise concerns, to record safety incidents and investigate and record near misses. An accident and incident book was kept in the service and we found that staff had been completing it appropriately.
- We saw that should an incident occur, staff would inform the manager of the service who would record the incident on the services spreadsheet, and conduct an investigation if necessary. We were told that the manager submitted a monthly return to the provider and franchisor.
- We reviewed the services incident log, this documented two incidents, one related to a fire in the door space to the service and one to a burglary at the service. We found that these incidents had been reviewed by the service although staff meeting mintues did not demonstrate that incidents were discussed and learning opportunities were taken. When we spoke with staff they confirmed that incidents were discussed during daily 'fire up' meetings.
- During the period November 2017 to October 2018 there had been no serious incidents requiring investigation. Serious incidents are events in health care where the potential for learning is so great, or the consequences to women, families and carers, staff or organisations are so significant, they warrant using additional resources to mount a comprehensive investigation.
- There had been no 'never events' in the previous 12 months prior to this inspection. Never events are serious incidents that are entirely preventable because guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- There had been no notifiable safety incidents that met the requirements of the duty of candour regulation in the 12 months preceding this inspection. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify women (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- An organisational policy and procedure was available to staff providing guidance on the process to follow if an incident was to occur that met the requirements of the duty of candour regulation.
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. The duty of candour regulation only applies to incidents where severe or moderate harm to a patient has occurred.
- Staff understood the duty of candour and the need for being open and honest with women and their families if errors occurred. The registered manager could explain the process they would undertake if they needed to implement the duty of candour following an incident, which met the requirements. However, throughout the reporting period, they had not needed to do this.
- The manager was aware of the requirements for reporting incidents to the CQC using the statutory notification route if this met the criteria, under Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Are diagnostic imaging services effective?

Good

Diagnostic imaging

Not sufficient evidence to rate

We do not currently rate effective for diagnostic imaging.

Evidence-based care and treatment

- **The service used current evidence-based guidance and good practice standards to inform the delivery of care and treatment.**
- Women's care and treatment was delivered and clinical outcomes monitored in accordance with guidance from the National Institute for Health and Care Excellence (NICE) and the British Medical Ultrasound Society (BMUS). NICE guidance was followed for diagnostic imaging pathways as part of care for uncomplicated pregnancies.
- Staff assessed women's needs and planned and delivered patient care in line with evidence-based, guidance, standards and best practice.
- In addition, the service followed principles, outlined in the 'Guidelines for professional ultrasound practice, 2017' by the Society and College of Radiographers (SCoR) and BMUS. Where possible, sonographers completed all ultrasound scans within 10 minutes to help reduce ultrasound patient dose.
- There was an audit programme in place to provide assurance of the quality and safety of the service. Peer review audits were undertaken in accordance with recommendations made by the British Medical Ultrasound Society, and the franchisor completed annual sonographer competency assessments.
- Other audits, such as clinic and local compliance audits were undertaken regularly. They monitored patient experience, cleanliness, health and safety, ultrasound scan reports, equipment, and policies and procedures.

Nutrition and hydration

- Women had access to water and hot drinks whilst awaiting their scan, there was also a small selection of snacks available for purchase.
- Women who were having a gender scan were encouraged to attend their appointment with a full bladder. This information was given to women when they contacted the clinic to book their appointment. It was also included in the 'frequently asked questions' on the service's website.
- If this was not possible we observed staff providing women with extra glasses of water to improve the quality of the ultrasound image

Pain relief

- Pain assessments were not undertaken at Window to the Womb although staff told us that women were made comfortable during the scanning process.

Patient outcomes

- **Staff monitored the effectiveness of care and treatment and used the findings to improve their practice.**

- The service monitored patient outcomes through their activity, annual patient satisfaction survey and clinical audits.
- Window to the Womb had recently introduced sonographer peer review audits. The sonographers reviewed each other's work and determined whether they agreed with their ultrasound observations and report quality and on such findings as gender or anomalies. This was in line with the British Medical Ultrasound Society (BMUS) guidance, which recommends peer review audits are completed using the ultrasound image and written report.
- The service reviewed and recorded how many women it had referred to the early pregnancy unit at a nearby NHS Hospital, the number of rescans it had conducted and the number of occasions the gender had been sought but was incorrect.
- There was a rescan guarantee in place for when it was not possible for the sonographer to confirm the gender of the baby at the time of the appointment. If the woman received incorrect information with regards to their baby's gender, they were offered a complimentary 4D baby scan.
- Further audits were conducted by the Window to the Womb lead sonographer ,these were completed

off-site and a report of findings following the review was sent to both the sonographer and the manager of the service to be discussed during their supervision to improve their practice.

- The lead sonographer would also visit the service to conduct on-site competency assessments. Sonographers also completed peer to peer audits.
- Other audits such as a 'clinical compliance audit' and local audits were conducted including, patient experience, health and safety, safeguarding, equipment and privacy and dignity. We found that audits were discussed at team meetings.

Competent staff

- **Staff had the skills, knowledge and experience to deliver effective care and treatment. While the sonographer staff files did not contain evidence of appraisals or references, there were processes in place to assess sonographer competence and suitability for their role.**
- The service made sure staff were competent for their roles. Managers appraised staff work performance and provided support.
- All staff had completed a structured induction programme for the service, which included the use of equipment and office systems.
- Sonographers had also completed a further induction programme under the direction of the provider's clinical lead.
- Records we checked confirmed staff received an annual appraisal and monthly supervision, which was up to date.
- We found that although sonographers could be employed and received professional development from the NHS, the service ensured that specific sonographer training was given at national meetings and by video learning, which had been developed by the franchisor.
- Staff had the right skills and training to undertake ultrasound scans, this was closely reviewed at the service with the clinical lead having the ability to review periodically sonographer's scans and provide feedback, this was possible as all scans completed at the service were videoed and uploaded to the central Window to the Womb IT systems to which the clinical lead could access.
- Each staff member completed a local induction, which included mandatory and role-specific training. Staff accessed their role-specific training through the service's electronic training portal. Training records confirmed that all staff had completed their appropriate role-specific training.

Multidisciplinary working

- **Staff of different disciplines worked together as a team to benefit women and their families.**
- We observed positive examples of the sonographer and scan assistants working well together. Their professional working relationship promoted a relaxed environment for women and helped to put women and their families at ease.
- Staff at the service told us that their aim was to work closely with women to support a seamless treatment pathway.
- If concerns were identified from a scan these were escalated to the patient's local NHS trust early pregnancy unit. We saw an example were this had taken place when a patient had been urgently transferred due to an ectopic pregnancy.
- However, in cases when this was not possible we saw that the Window to the Womb nurse specialist had developed a process for referral to the NHS when the early pregnancy unit were unable to accept the patient.

Seven-day services

- **Although Window to the Womb was not an acute service and did not offer emergency tests or treatment, it still operated in a flexible way to accommodate the needs of the women.**
- The service was operational from 4pm to 8pm Monday, Wednesday and Friday and 9.30am to 5.30pm on Saturdays and Sundays however opening times were flexible to meet the demands of the service.

Good

Diagnostic imaging

- Appointments were flexible to meet the needs of women, and appointments could be made available at short notice if required.

Health promotion

- Information leaflets were provided in the service for women on several topics. For example; what the scan would entail, keeping healthy, which included giving up smoking and alcohol, movements of the baby, foods to be avoided.
- The service also provided a list of questions to women they could ask of their midwife and information concerning pregnancy and group B STREP (Group B Streptococcus is a bacterium found in one in five women in the UK which in a small number of cases can cause complications that can be life threatening to a baby.)

Consent and Mental Capacity Act

- **Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. They followed the service policy and procedures when a woman could not give consent. All staff were aware of the importance for gaining consent from women before conducting any ultrasound scan.**
- Women completed a consent form, staff understood their responsibility to gain consent from women before they performed an ultrasound scan. They recognised and respected a patient's choice if they decided not to have a scan after arriving for an appointment.
- Staff informed us they explained the imagining procedure to women and as well as requiring women to complete an informed consent form, a verbal request was also made. We found that staff we spoke with had knowledge of the requirements of the Mental Capacity Act 2005 (MCA).
- There was a Mental Capacity Act (2005) policy for staff to follow, which clearly outlined the service's expectations and processes. However, staff told us that since starting the service they had not had to support women who had been assessed as lacking capacity to make decisions about the scanning procedure.

Are diagnostic imaging services caring?

Good

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

Compassionate care

- **Staff cared for women with compassion. Feedback from women and their families confirmed that staff treated them well and with kindness.**
- All staff were very passionate about their roles and were dedicated to making sure women received patient-centred care.
- We observed staff treating and assisting women and their families in a compassionate manner. The scan assistants and sonographer were very reassuring and interacted with the women and their relatives in a professional, respectful, and supportive way.
- Women we spoke with said staff demonstrated a kind and caring attitude to them. They told us they had a, 'Great experience they were very patient with our baby (during the scan) and gave us great images to keep as memories.' 'Absolutely brilliant' and 'I am very pleased, amazing staff and a very good experience 100% recommend.'
- The service ensured that women's privacy and dignity was maintained during their time in the unit and during scanning. Scanning rooms had a 'No entry' sign and in the room women could use a privacy screen when getting undressed.
- The service obtained patient feedback through feedback forms, which allowed women to make comments about their care and provide a rating of their overall experience, however most women chose to provide feedback online. Paper feedback forms represented 5% of feedback received by the service.
- Online we saw that the service was rated as 'Five star" by 99% of women, the service collected information

Good

Diagnostic imaging

based on ease of booking, initial welcome by the team, care provided, hygiene and comfort and an overall rating, along with 4.8 and 4.9 out of five star ratings on social media.

Emotional support

- **Staff provided emotional support to women to minimise their distress. We observed staff providing kind, thoughtful, supportive, and empathetic care.**
- Staff provided reassurance throughout the scanning process, they updated the patient on the progress of the scan and how long they had before their scan was complete.
- Staff felt recognising and providing emotional support to women was an important aspect of the work they did, staff had received training in discussing potentially bad news. The service had a separate room were, if necessary, scan results could be discussed but we were told that the service would use the scanning room which was equipped with comfortable seating,
- If a woman became distressed in a public area, such as the waiting room, they allowed the woman to sit in a separate room, where a member of staff would support them.

Understanding and involvement of women and those close to them

- **Staff involved women and those close to them in decisions about their care.**
- Staff communicated with women in a manner that would ensure they understood the reasons for attending the unit. All women were welcomed into the reception area and reassured about their procedure.
- Staff recognised when women or relatives needed additional support to help them understand and be involved in their care and treatment. Staff enabled them to access this, including access to interpreting and translation services.
- Women and relatives could ask questions about their scan. A range of ultrasound related leaflets were available to women in the service. Women could also access information on different types of scans, and pricing information from the Window to the Womb website.
- Staff also communicated to relatives in a way they could understand. This included any children who may have accompanied the woman to their appointment. The registered manager told us that up to five people were welcome to attend the appointments with the woman.
- All relatives we spoke with said that they felt involved in the care given.

Are diagnostic imaging services responsive?

Good

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

Service delivery to meet the needs of local people

- **The facilities and premises met the needs of the range of women who accessed the service. The service also recognised that women's preferred method of communication had changed, and as a result, they had developed a range of innovative products to tailor their services and meet the needs of local people.**
- The diagnostic service was located on the ground floor of the building women and visitors could access this step free. In case of emergency the service could access emergency exits to the front and rear of the service.
- The service provided payment details in a confirmation email prior to each patient's attendance. These included a clear price list and different options for payment. The service was registered with UK insurers for the provision of care and public liability.
- The service offered a number of scans for pregnant women such as, well-being, viability, growth and presentation, gender together with the ability for digital images to be printed.

Good

Diagnostic imaging

- The service provided evening and weekend appointments to meet the requirements of women.
- The service recognised that women preferred to use the internet or mobile phone applications ('app') to contact the clinic and book appointments. Therefore, women could book their scan appointments through the phone, website or through the free Window to the Womb phone app.
- The service was was accessible by public transport being located close to bus routes, the service could be accessed by car, with public carparks within walking distance. The service provided information on travelling to the centre on its website.

Meeting people's individual needs

- **The service took a proactive approach to understand women's individual needs, and delivered care in a way that met these needs, which was accessible and promoted equality.**
- Staff had an understanding of the cultural, social and religious needs of women. There was a diverse staff group with multilingual and diverse faith backgrounds.
- During scanning, staff made women comfortable. Women were advised that if they wanted to stop their scan, staff would assist them and discuss choices for further imaging or different techniques or coping mechanisms to complete their imaging.
- Relatives could be present in the scanning room if required.
- There were no restrictions for women with reduced mobility needs. Couches were suitable for bariatric (relating to the treatment of obesity) women.
- Staff told us the patient would inform them if translation services were required and they would organise this in advance. Staff told us that there had never been a requirement for translation services, but they could use services available on mobile phones.
- Easy to read leaflets and large print patient information was available and braille could be provided on request.

Access and flow

- **Women could access services and appointments in a way and at a time that suited them. Technology was used innovatively to ensure women had timely access to treatment.**
- Women self-referred and they could book appointments through several media platforms including, telephone and email through the Window to the Womb website. Appointments were usually made by telephone at a time and date agreed by them.
- In the case of a requirement to conduct a scan at short notice the service told us that it would attempt to make an appointment as soon as possible.
- There were very few delays and appointment times were closely adhered to. Fetal well-being reports were produced and shared in a timely manner, on the same day.
- During our inspection, we observed that the Firstscan and Window to the Womb clinics ran on time.
- From November 2017 to October 2018 no planned examinations were cancelled for

  non-clinical reasons and no planned examinations had been delayed in the same period.
- The service did not routinely record the data for women who did not attend, we were told that if a person did not attend or cancel they would be contacted to ascertain the reasons for their non-attendance and an appointment would be re-booked if necessary.

Learning from complaints and concerns

- **The service treated concerns and complaints extremely seriously. The regional manager completed comprehensive investigations, which frequently involved input from other professionals, such as the lead sonographer. Lessons learned were shared with all staff.**
- Staff were encouraged to resolve complaints and concerns locally. The service had a complaints handling policy and all staff had completed a mandatory training course on customer care and complaints.

Good

Diagnostic imaging

- Information on how to make a complaint was available on the clinic website and on the back of the patient feedback form. Staff told us that most complaints were made through social media. Therefore, staff monitored their social media pages daily, to ensure any concerns or complaints were addressed immediately.
- The clinic had a complaints log. This recorded the unit had received 13 complaints two of which had been upheld in the period November 2017 to October 2018. All were managed through the informal complaints procedure.
- The complaints log recorded actions the unit had taken in response to the complaint. The log recorded when women had received a verbal apology from the service. Although most complaints related to the quality of the picture image.
- Although we were told that information from complaints was shared at daily 'fire up' meetings and staff meetings, we did not see evidence of this.
- All staff completed a mandatory training course on customer care and dealing with complaints.

Are diagnostic imaging services well-led?

Good

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

Leadership

- **Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.**
- At the time of the inspection the service did not have a registered manager in place. Although the manager had recently begun the application process to become registered with the Care Quality Commission. (A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for the meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run).
- The manager was supported by the Nominated Individual (the nominated individual is responsible for supervising the management of the regulated activity provided) and by the Window to the Womb franchisor.
- The management structure consisted of a manager supported by a senior scan assistant. Staff also had specialist lead roles within the unit. For example, the manager was the lead for health and safety, safeguarding, and infection prevention and control (IPC). The manager was also supported by a regional operations manager on behalf of the provider.
- All staff spoke positively about the manager of Window to the Womb and the franchise directors. They said the manager and directors were friendly, approachable, and effective in their roles. Staff felt confident to discuss any concerns they had with them.
- Staff said managers were visible and approachable. Staff informed us they felt supported by the management team. All the staff we spoke with were positive about the management of the service.
- The franchisor was contractually responsible for providing the manager with ongoing training, which was undertaken at clinic visits, training events and the biannual national franchise meetings.

Vision and strategy

- **Window to the Womb had a clear vision and strategy for what they wanted to achieve, with quality and sustainability as the top priorities.**
- The services vision and aims were to provide expectant parents with first class, independent ultrasound services within their local community.
- All staff were introduced into these values during induction when first employed during the corporate induction. The appraisal process for staff were also aligned to these values of the service and individuals learning objectives.
- The service had also identified values, which underpinned their vision. Their values included: dignity, integrity, privacy, diversity, and safety.

Good

Diagnostic imaging

Culture

- **Managers and staff promoted a positive culture, creating a sense of common purpose based on shared values.**
- All of the staff we spoke with were very positive and happy in their roles and stated the service was a good place to work. Staff told us that the manager was flexible in their approach to running the service, stating that the manager was considered a friend.
- Staff we spoke with told us they felt supported, respected and valued, they were actively encouraged to make suggestions about changes and improvements to the services provided.
- The service operated an open and honest culture to encourage team working within the organisation. This was supported by the franchisor's 'freedom to raise a concern' policy, and the appointment of a 'freedom to speak up guardian'.
- Staff demonstrated pride in their work and the service they delivered to women and their service partners. Staff told us they had sufficient time to support women.
- Staff told us there was a positive approach regarding incidents and they always received feedback from incidents.
- Equality and diversity were promoted within the service and was part of mandatory training.
- A whistle blowing policy and a duty of candour policy were in place. The service also provided staff with a leaflet developed by Window to the Womb outlining how to raise a concern and what response they could expect. Staff told us they had attended duty of candour training and described to us the principles of duty of candour.

Governance

- **Governance arrangements were clear and appropriate to the size of the service**
- The manager had overall responsibility for clinical governance and quality monitoring. This included investigating incidents and responding to patient complaints.
- The manager was supported by the provider and franchisor they attended biannual national franchise meetings, where clinic compliance, performance, audit, and best practice were discussed.
- There was an audit programme in place to provide assurance of the quality and safety of the service. Peer review audits were undertaken in accordance with recommendations made by the British Medical Ultrasound Society, and the franchisor completed annual sonographer competency assessments. Other audits, such as clinical and local compliance audits were undertaken regularly. They monitored patient experience, health and safety, equipment and privacy and dignity.
- Formal minuted team meetings were held monthly. We were provided with minutes from these meetings which included; how the unit was progressing in regard to the company strategy, performance, policies, and reviews of incidents and complaints and any lessons learnt.
- The manager also ensured that regular health and safety audits were conducted monthly. This ensured actions to improve services were recorded and monitored for completion.

Managing risks, issues and performance

- **The service had effective arrangements in place for identifying and recording risks, and there was evidence that these risks and their mitigating actions were discussed with the wider team.**
- There was a local risk assessment system (risk register) which included a process of escalation to escalate risks it was reviewed and updated monthly and new risks added regularly, these covered hazards and precautions in relation to a range of factors, including infection control, electrical safety, fire safety and substances hazardous to health.
- Risk assessments were completed on a standard template to ensure consistent information was used. All templates had the risk identified, mitigating/ control measures, the individual responsible for managing the risk and the risk assessment review date. There was also evidence that the risk assessments had been circulated to all employees and the management team for review.

- There was a business continuity policy which highlighted key hazards and mitigations, contact details and relevant staff and an emergency response checklist.
- The service also used patient feedback, complaints, and clinical audit results to help identify any necessary improvements and ensure they provided an effective service.

Managing information

- **The service managed and used information to support its activities, using secure electronic systems with security safeguards.**
- The provider collected, analysed, managed and used information to support all its activities, using secure electronic systems with security safeguards.
- Window to the Womb was registered with the Information Commissioner's Office (ICO), which is in line with 'The Data Protection (Charges and Information) Regulations' (2018). The ICO is the UK's independent authority set up to uphold information rights.
- Staff told us there were sufficient numbers of computers in the unit. This enabled staff to access the computer system when they needed to.
- All staff we spoke with demonstrated they could locate and access relevant information and records easily, this enabled them to carry out their day to day roles. Patient records could be accessed easily but were kept secure to prevent unauthorised access to data.
- Information from scans could be reviewed remotely by referrers to give timely advice and interpretation of results to determine appropriate patient care.

Engagement

- **The service engaged well with women, staff and the public to plan and manage appropriate services and collaborated with partner organisations effectively.**
- The service did not routinely undertake staff satisfaction surveys, it was explained that because the service had a relatively small number of permanent employees that numbers would not produce meaningful data. It was explained that staff had access to the manager, regional manager and nominated individual all of whom operated an open-door policy. They told us that regular supervision and appraisal ensured the service provided staff with the opportunity to comment on the service.
- The service also enabled women to provide feedback by email or comment cards. We reviewed the feedback received by the service from women which was wholly positive.
- There was a website for members of the public to use. This held information regarding the services offered and the prices for each type of scan. There was also information about how women could provide feedback regarding their experience. Similarly, women were encouraged to leave feedback on the service's social media pages.

Learning, continuous improvement and innovation

- **Staff could provide examples of improvements and changes made to processes based on patient feedback, incidents, and staff suggestion.**
- The service offered women such things as 'Instant Midwife', this was a service available via social media messaging systems, that would provide answers to the most common questions asked by expectant women it also offered a application available for mobile phones which enabled women to view pictures of their baby via this media.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that it has a programme in place to conduct hand hygiene audits.
- The provider should ensure that it has processes in place to share learning from incidents with all staff.
- The provider should ensure that the has a manager in place as accordance with its conditions of registration.