Window to the Womb

Quality Report

Window To The Womb
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Window To The Womb is operated by 1st Glimpse Ltd. Facilities include a ground floor single storey clinic with direct access from the pedestrianised shopping centre. There is one scan room, reception area, kitchen and staff area. The scan room contains an ultrasound machine, medical couch, sofa, sink and projector.

Window To The Womb offer a wide variety of gender scans and 4D ultrasound scans. They provide diagnostic obstetric ultrasound services for pregnant women (aged 18-65) from six weeks to full term.

We inspected this service using our comprehensive inspection methodology. We carried out the short notice announced part of our inspection on 11 February 2020.

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

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

Services we rate

We had not previously rated the service. We rated it as **Good** overall.

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care.
- Managers appraised staff's work performance annually and checked to make sure staff had the right qualifications and professional registration for their roles.
- Staff understood how to protect women from abuse and the service worked well with other agencies to do so.
- Staff kept detailed records of patients' care and treatment and records were up-to-date, stored securely and easily available to all staff providing care
- Women could access services and appointments in a way and a time that suited them. The service used technology innovatively to ensure women had timely access to ultrasound scans.
- The service provided care and treatment based on national guidance.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them.
- Staff were caring, compassionate, kind and engaged well with women and their families.
- The service treated concerns and complaints seriously. If a complaint received the registered manager would complete a comprehensive investigation and share lessons learnt with all staff.
- 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 women and staff.
- Staff worked well together. They supported and respected each other.
- Staff felt respected and valued. They were focused on the needs of women and their families.

Summary of findings

However:

- Written reports were not clearly written meaning that it was difficult to interpret scan details.
- The clinical waste bin located outside the clinic did not have a lock meaning that clinical waste was not stored securely.
- Information leaflets were not available in any language other than English

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

Name of signatory

Heidi Smoult

Deputy Chief Inspector of Hospitals

Summary of findings

Contents

Good

Window To The Womb

Services we looked at:
Diagnostic imaging

Summary of this inspection

Background to Window to the Womb

Window To The Womb is operated by 1st Glimpse Ltd. The service opened in May 2015. It is a private ultrasound clinic in Witham, Essex that provides diagnostic pregnancy ultrasound services to self-funding women, who are more than six weeks pregnant. All ultrasound scans performed at Window To The Womb are in addition to those provided through the NHS. The service primarily serves the communities of Essex. It also accepts women from outside this area.

The service has had a registered manager in post since 2015.

The service was registered with the CQC to undertake the regulated activity of diagnostic and screening procedures. We have not previously inspected this service.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector and one other CQC inspector. The inspection team was overseen by Mark Heath, Interim Head of Hospital Inspection.

Information about Window to the Womb

The service provides diagnostic imaging service (ultrasound scans) to self-funding pregnant women aged 18 and above across Essex. The service is a single storey clinic located in a shopping precinct.

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

During our inspection, we visited the reception area, the scanning room and the storage room. We spoke with six members of staff including the clinic manager, regional manager, franchise director, a sonographer and two scan assistants. We spoke with two women and their relatives. During our inspection, we reviewed 10 sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the services first inspection since registration with the CQC in 2015.

The service employed one full time sonographer and six scan assistants.

Activity (January 2019 – January 2020):

• First Scans (6-15 weeks): 1626 scans

• Wellbeing and gender (16 weeks plus): 1866 scans

• 4D scans (24-34 weeks): 1833 scans

• Growth and presentation scans (26 weeks plus): 87 scans

Track record on safety:

- Zero never events
- Zero clinical incidents
- One serious incident related to safeguarding
- 13 complaints (June 2018 – June 2019)
- 544 compliments (June 2018 – June 2019)

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

Are services safe?

We rated safe as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect women from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well infection. They kept equipment and the premises visibly clean.
- Staff completed and updated risk assessments for each patient.
- The service had enough staff with the right qualifications, skills, training and experience.
- The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned.

However:

- The hand-written referral records were not clear and easily legible meaning that it was difficult to interpret scan details.
- The clinical waste bin located outside the clinic did not have a lock.

Are services effective?

Are services effective?

We do not rate effective, however:

- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.
- The service made sure staff were competent for their roles.
- Staff worked together as a team to benefit women.
- Staff supported women to make informed decisions about their care and treatment.

Are services caring?

Good

Are services caring?

We rated it as **Good** because:

- Staff treated women with compassion and kindness, respected their privacy and dignity.
- Staff provided emotional support to women, families and carers to minimise their distress.

Summary of this inspection

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

Are services responsive?

Good

Are services responsive?

We rated it as **Good** because:

- The service planned and provided care in a way that met the needs of local people and the communities served.
- The service was inclusive and took account of women's' individual needs and preferences.
- People could access the service when they needed it.
- 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.

However:

- Information leaflets were not available in any language other than English

Are services well-led?

Good

Are services well-led?

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

- 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 women and staff.
- The service had a vision for what it wanted to achieve.
- Staff felt respected, supported and valued. They were focused on the needs of women receiving care.
- Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and staff actively and openly engaged with women and staff. They collaborated with partner organisations to help improve services for women.
- The service was committed to learning and improving services.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	N/A	Good	Good	Good	Good

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Good

Mandatory training

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

Staff were up to date with their mandatory training. Topics included infection control, fire safety and equality and diversity and mental capacity. At the time of our inspection 100% of staff had completed their mandatory training.

Mandatory training was delivered by a combination of on-line training and face to face training. Face to face training was delivered during the monthly staff meeting.

Mandatory training compliance was monitored by the clinic manager. They monitored completion and advised staff when training was due. Staff confirmed that they were given time to do training.

The clinic manager also attended annual updates for mandatory training. At these meetings they were updated as to any changes in mandatory training and provided with resources to deliver training to staff in the clinic as required.

Safeguarding

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

The provider had an up to date safeguarding policy that reflected legislation and local requirements in place that was accessible to all staff. Staff we spoke with were aware of the policy and knew how to access it

There were clear safeguarding processes and procedures in place. Clinic staff were trained to safeguarding level two for both vulnerable adults and children. This was in line with the expectation of training for this staff group in this setting, as referred to in the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition: January 2019 intercollegiate document.

The clinic manager was trained to level three safeguarding for both vulnerable adults and children.

The franchise had a national safeguarding lead who was trained to safeguarding level 4. Staff could access support from the national lead if required and reported that they knew how to access the safeguarding lead. They told us that that the lead was responsive and supportive.

Staff knew what constituted a safeguarding concern and how to escalate them appropriately. They were able to give examples of what constituted a safeguarding concern. A member of staff told us about a recent safeguarding concern and was able to demonstrate that appropriate action had been taken and that the concern was escalated appropriately.

Safeguarding scenarios were discussed during team meetings to ensure that staff were aware of what to do if they had safeguarding concerns.

The provider performed scans on 16 & 17 year olds but only when accompanied by an adult who was legally responsible for them, for example a parent or guardian.

Good

Diagnostic imaging

Cleanliness, infection control and hygiene

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

All areas we visited were visible clean and tidy.

There was an infection control policy in place which was within review date and accessible to staff.

Personal protective equipment (PPE) such as gloves were available for staff to use.

We observed staff washing their hands before and after each scan. We saw that they cleaned equipment after use. The couch was wiped clean after every scan using appropriate cleaning wipes. Sonographers wore gloves when carrying out scans in line with infection protection and control compliance.

The service conducted hand washing audits to ensure that staff were compliant with hand washing. Audit results from July 2019 showed 100% compliance. However, we did not see evidence that an audit had been completed since then.

Sonographers used single use probe covers when undertaking trans-vaginal scans. During the early stages of a pregnancy it is sometimes necessary to conduct an internal scan to observe the fetus. Probe covers were disposed of in the clinical waste bin after each patient use. The probes were then cleaned with the recommended disinfectant. All staff were trained in cleaning ultrasound probes and had certificates in competency folder to evidence successful completion of the training.

Staff were responsible for cleaning. The clinic manager told us that the clinic was cleaned daily but there was no daily cleaning check sheet. We were therefore not assured that all areas had been cleaned as required. We raised this at the time of inspection and the clinic manager told us that they would review this.

The clinic manager did a weekly cleaning check audit to ensure the clinic was clean. This was completed every week for the previous two months prior to our inspection.

However, we found that the bottom drawer of the clinic trolley contained a folder that was visibly dusty. We brought this to the attention of the manager who ensured the folder was cleaned.

Staff completed a deep clean every month. We checked the deep cleaning records and saw that deep cleans had been undertaken in the six months prior to our inspection.

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 environment was fit for the purpose for the service provided.

The scanning room was spacious and contained a couch, scanning machine and seating area for family and friends. There were two monitors and a large screen positioned so that the woman and their family could see the scan clearly.

Equipment servicing and maintenance was provided through a service contract with the machine manufacturer. We checked the service record and saw that the equipment was serviced annually in line with the manufacturer recommendations. We checked five pieces of equipment and saw that they were within service date and had an up to date electricity safety check.

The sonographer escalated concerns if there was a problem with image quality. Staff we spoke with told us the service contract provider was responsive if there was an equipment fault. In the event of a mechanical failure the company that provided the scanning machines and equipment had stand by machines that the service could use which were received within 24 hours of reporting.

The clinic was uncluttered, and equipment was stored appropriately. Staff completed daily in-house checks which included the scan room, toilet, reception area and the store room. The service had adequate space to store additional equipment and souvenirs.

Good

Diagnostic imaging

The service stored cleaning materials in a locked store cupboard in line with the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the legislation which requires employers to control substances which are hazardous to health.

Waste was separated and disposed of appropriately. Clinical waste was collected by an external provider who provided clinical waste bins. We saw that the outside clinical waste bin outside premises was not locked. This meant that people without authorisation could access the bin. We escalated this at the time of our inspection. Following our inspection, the provider told us that they had organised a replacement waste bin that could be locked which was due to arrive by the end of February. We checked with the clinic manager as to whether the order had been completed and they told us that the new clinical waste bin had yet to arrive at the location.

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 women at risk of deterioration.

There was a clear pathway in place that staff could follow in the event of anomalies seen by the sonographer on the ultrasound scan. This involved informing the woman that they had seen something on their scan which needed to be checked at the hospital for a full clinical diagnosis.

Staff made referrals to the women's place of choice where they were undergoing NHS care. They told us they contacted the NHS service directly and ensured the woman had an appointment at the relevant NHS clinic. The registered manager told us if they were unable to secure an appointment before the woman left the clinic, they would contact them later to confirm an appointment time.

The Window To The womb franchise employed a sonographer clinical lead who was available to review scans remotely whilst the woman was still at the clinic. This service was used if the sonographer required a second opinion of the scan. Referrals were made on dedicated referral sheets. Referrals that were made were documented, stored securely and monitored by the clinic manager as to how many had been made each month. We reviewed four referrals and saw they contained the woman's details and the reason for the referral. However, the hand-written report was not always clear and easy to read, meaning that other health care professionals reading the referral may not be clear about what had been seen on the scan.

Women were asked to bring along their NHS maternity medical record when they came to the clinic. This was to help assure the service that the woman was on an NHS maternity pathway. We saw staff advising women to continue with their NHS scans as part of the maternity pathway.

When an ectopic pregnancy was detected during a scan staff told us that they immediately contacted 999 to get the woman to the local hospital to be treated. They told us they would keep the 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 and a high temperature. Contact details of local hospitals were given to women in an information pack.

The service did not require a resuscitation trolley. There was a first aid box which was sealed and within expiration date. Staff were up to date with adult and children first aid training. Staff told us in case of an emergency they would call 999.

Staffing

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

The service operated with a qualified Sonographer, clinic manager and scan assistants. For wellbeing clinics there were three scan assistants plus a sonographer routinely rostered and two scan assistants plus a sonographer worked in the early pregnancy clinics.

The service employed seven scanning assistants and one sonographer overseen by a clinic manager. This was to ensure there was enough staff to cover the clinic sessions and sickness and holidays.

Good

Diagnostic imaging

For the early pregnancy scan clinics there was always a minimum of three staff members on duty plus the sonographer. This was to ensure enough staff were on site should an anomaly be found on the scan and additional staff were required to support the woman and those accompanying her for the scan. For well being clinics there was a minimum of two scanning assistants plus the sonographer. The sonographer was supported by a scanning assistant as chaperone for every scan.

All staff received a full induction, which included completion of mandatory training and being aware of policies and procedures. There were different inductions for staff depending on their job role.

In the event of staff sickness or holiday the service used agency staff. Agency staff were employed through an approved supplier.

At the time of the inspection the regional manager told us they had employed an additional sonographer to provide holiday cover and support the peer review programme.

Records

Staff kept detailed records of women's care and treatment. Records were, up-to-date and stored securely. However, we found that records were not always written clearly. Records were easily available to all staff providing care.

Records were maintained by paper and electronic means. Paper records were stored in a locked filing cupboard. Electronic records were password protected.

We reviewed 10 sets of records including onward referral forms. Staff accurately recorded the information. Information included, the woman's estimated due date, observations of the scan, conclusions and gender (if requested). However, we found that scan reports were not always easily legible meaning information that was shared with other healthcare providers might be difficult to interpret. We raised this at the time of the inspection and the regional manager assured us that they would address the concern with the team.

On arrival women completed a registration form. This was kept at reception in a covered clip board prior to the woman being called in to the scanning room.

Records were kept in a locked filing cupboard in the reception area. The service had a central storage point off site where records were records were stored securely.

Ultrasound images were stored on the scanner which was password protected.

Incidents

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

Staff reported incidents and appropriate action was taken. The service used a paper-based reporting system and had an accident and incident book available in the clinic.

The clinic manager was responsible for conducting investigations into all incidents supported by the regional manager, franchisee and in relation to more serious incident the franchise directors.

Staff told us about an incident which involved the missed diagnosis of a fetal anomoly during an early pregnancy scan. The director told us that as result of this incident the member of staff received additional training around the anomaly. A bespoke training programme was delivered to all sonographers around detecting this fetal anomaly and the action that should be taken.

Staff were aware of the term duty of candour. They understood the principle behind the regulation and the need to be open and honest with women and apologise if incidents occurred. The duty of candour is a statutory (legal) duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. The director told us about an incident and how a woman and her partner were involved in the investigation and kept informed of changes made following the incident. The clinic manager told us that the woman had a l second pregnancy and had attended the clinic for scans.

Good

Diagnostic imaging

Although incidents were reported there was no formal incident policy in place. We raised this as a concern at the time of our inspection. Following the inspection, the provider sent us a copy of an incident policy that was to be implemented with immediate effect.

We reviewed team meeting minutes from May 2019 to September 2019 and saw that feedback from incidents and complaints was discussed at each team meeting.

Start here...

Are diagnostic imaging services effective?

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 protected the rights of women subject to the Mental Health Act 1983.

Local policies and protocols were evidence-based in line with national guidance anomaly

We reviewed four policies which were up to date and within review date. The policies were written centrally by the franchise. Staff were made aware of updates to policies at monthly team meetings and signed to confirm that they had been notified of any updates.

Staff worked to as low as reasonably achievable (ALARA) guidelines. ALARA is defined as a fundamental approach to the safe use of diagnostic ultrasound using the lowest output power and the shortest scan time possible. During our inspection, staff were working within these guidelines when undertaking an ultrasound scan.

The service had an audit programme in place to provide assurance of quality and safety within the service. Regular audits and clinical reviews were completed. Audits were carried out internally and there was an annual audit conducted by the franchisor. This included a review of risk assessments, policies and staff training. The franchisor completed annual sonographer competency assessments and an annual clinic audit. We reviewed records and saw that these had been completed annually as per the guidance.

Nutrition and hydration

Women did not spend an extended amount of time in the service. Water was available and there were outlets to buy food and drink nearby the service location.

Pain relief

Staff did not formally monitor pain levels. However, we saw staff asked women if they were comfortable during their scan.

Patient outcomes

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

All referrals to the NHS were documented on the woman's form and clearly explained to them Records of women who had been referred were retained and stored securely by the service. Although referral monitoring was part of the service's monthly audits the service was not informed of the outcome of the referral due to patient confidentiality.

Window To The Womb Ltd reported a 99.9% accuracy rate for their gender confirmation scan.

The clinic manager monitored feedback through a variety of social media platforms. Women were given a feedback form following their scan and were encouraged to give feedback. Feedback, compliments and complaints were shared at team meetings and any learning discussed.

Competent staff

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

Staff training

All staff received a comprehensive induction. Scanning assistants completed a training and induction programme including chaperone training. Sonographers received a full induction which included working alongside a currently employed sonographer. Scanning competencies were signed off by the clinical lead sonographer. The clinical lead sonographer was also available to offer clinical advice when needed.

Good

Diagnostic imaging

The service provided ongoing training for staff and managers. This was delivered during team meetings. For example, the clinic manager told us they discussed safeguarding scenarios in the meeting to ensure staff were up to date with actions they would take if they had a safeguarding concern.

The sonographer had an annual competency assessment that was provided by the clinical lead sonographer employed by the Window To The Womb franchise. We saw evidence that the sonographer had received annual reviews by the franchises lead sonographer.

There was a process of peer review in place. Sonographer scans and reports were reviewed by a sonographer colleague to ensure sonographer competencies were up to date. The regional manager told us they were in the process of employing an additional sonographer to support this process.

The sonographer told us that peer review provided an opportunity to stay up to date and share and learn from other sonographers' experiences. Sonographers within the service were registered with the Health and Care Professions Council (HCPC) and registrations were up to date.

Staff received an annual appraisal. Information provided by the service showed that 100% of staff had received their annual appraisal.

Agency staff were employed through an approved supplier. All agency sonographers had been through a full induction and approved by the provider.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit women. They supported each other to provide good care and communicated effectively with other agencies.

During our inspection we saw that the team worked well together and communicated well with each other. This included the franchise director, regional manager, clinic managers, sonographers and scan assistants.

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

The service had links with the local NHS trusts to ensure that they had effective referral pathways for women when required. Staff told us they had established good working relationships with local trusts and were able to telephone the service to secure an appointment for the woman before she left the clinic.

Staff were also able to contact the local safeguarding team should they need to make a referral.

Seven-day services

The service was not available seven days a week. However, the service had organised clinic lists to enable access to the service.

The normal clinic operating hours were Monday, Tuesday and Thursday 3pm to 9pm and Saturday and Sunday 9am to 6pm.

The service had appointments in the evening and weekend to allow women to easily access the service.

Booking for appointments was available seven days a week 24 hours a day using the franchise online booking system available to their website.

Health promotion

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

The service provided leaflets that contained information for "mums to be". This included eating well, stopping smoking, not to drink alcohol and foods to avoid. Smoking cessation posters were displayed in the clinic advising women of the harm that smoking can do to their unborn baby.

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.

We saw that there was a community board featuring yoga, swimming and other healthy activities that pregnant women can participate in should they choose.

Consent and Mental Capacity Act

Good

Diagnostic imaging

Staff supported women to make informed decisions about their care and treatment. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff we asked were aware of the Mental Capacity Act and its application although they could not recall as time when they had a concern about a woman's capacity to consent to a scan.

Before their scan all women received written information to read and sign. This included information about ultrasound scanning and safety information, a pre-scan questionnaire and declaration form which included terms and conditions. There was a self-declaration stating the woman were receiving or intended to receive maternity care through the NHS and consented to information being shared with the NHS.

For early pregnancy scans, women were given additional information that told them more about the scan and information should the sonographer need to perform a trans vaginal 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 outcomes. We observed that the sonographer explained the scan to women and their families and obtained verbal consent before commencing scanning.

Are diagnostic imaging services caring?

Good

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. We observed staff treating women and their family and friends with kindness and courtesy.

Women were treated with dignity screen and respect. The door to the scanning room was always kept shut during the scan to ensure that the woman's privacy was maintained. Women who required a trans vaginal scan were provided with a screen to get changed behind and a basket to keep their clothing in. They were provided with a towel to cover themselves during the scan.

Throughout the scan the sonographer checked that the woman was comfortable and had no concerns.

There was a scan assistant in the scanning room with the sonographer for all scans. The scan assistant acted a s a chaperone and offered support to the women and their families.

We reviewed feedback from those who had used the service one woman had commented, that the staff were "amazing and helpful". Women and their families said that they would recommend the service to other people.

Emotional support

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

The service held separate clinics for early scans and 16+ week scans. Staff were mindful that early scans held a higher risk of complications being identified.

The sonographer initially started the scan without the other screen in the room being turned on. This meant that if any anomalies were identified the sonographer could make their diagnosis and share the information in an informed compassionate manner. We observed that staff were calm and reassuring throughout the scan the sonographer provided reassurance about what was being imaged and displayed on the screen and shared what they observed.

Staff informed us that in the event of finding abnormal results women and their partners would remain in the scanning room whilst a referral was made to an NHS provider. Women that received bad news were able to leave by an alternative exit if they preferred so they did not have to leave passing the waiting room where other women were waiting for their scan.

Staff were invested in ensuring the experience of having a scan was special for the women and their families and appeared to share in the excitement of the experience.

Good

Diagnostic imaging

Understanding and involvement of women and those close to them

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

Family and friends were welcome in the scan room and there were three screens positioned in the room to ensure that everyone in the room could see the scan images.

We saw staff speaking to family members and involving them with the scan and checking that they were ok. We observed a scan taking place where a sibling was present, and the sonographer and scan assistant ensured that they were included.

The regional manager told us that they encouraged a a "non-judgemental" approach and their priority was to ensure everyone had a unique and special experience. This was confirmed by all the staff that we spoke to.

Are diagnostic imaging services responsive?

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. It also worked with others in the wider system and local organisations to plan care.

The service operated extended opening hours to enable women to access the service in the evening and at weekends. Staff told us that women could access an appointment when they required one and where necessary additional appointment slots could be made available.

The clinic was located in a retail area. It was easy to find and clearly signed outside. Free parking was available at the local supermarket.

There was a large waiting area with sofas and chairs for the women and their families to sit whilst they waited. Children's toys were available. There was a variety of different scan packages for the women to choose from. Details of these were available at the clinic and on the services website. A wellbeing scan was included as part of all the packages.

The service had established good working relationships with local trusts and there were established referral pathways to the NHS.

Meeting people's individual needs

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

The service held separate clinics for early pregnancy scans (6-15+6 weeks) and window scans (16 + weeks). Window scans was the term the service used for later pregnancy and wellbeing scans. Staff told us that there was a higher likelihood of abnormalities being detected in early stages of pregnancy. Holding separate clinics meant if a woman was given bad news, had experienced pregnancy loss or were anxious about their pregnancy they did not have to share the same area with women who were much later in their pregnancy. Staff told us that that souvenirs were only displayed at the well-being scan clinics.

The clinic was accessible for people with reduced mobility. The clinic was a ground floor single storey building. The toilet was accessible for people who used a wheel-chair.

Staff had access to a translation service for women who did not speak English.

The service provided information leaflets for women using the service. However, the service did not provide leaflets in different languages.

The service provided a 'read aloud' system which made it more accessible to women who were visually impaired, had hearing loss or could not read.

Following their scan images were uploaded to an app. Women were given a unique access code to their scan images. They were then able to share this image with friends and family of their choosing.

Good

Diagnostic imaging

Staff told us they had not had anyone attend the clinic who required additional support. However, they explained that they would consult with the woman and their family and make any reasonable adjustments where possible to enable them to access the service.

Access and flow

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

The service was not open seven days however, morning, evening and weekend clinics were available to allow women access to the service outside of working hours

Bookings could be made online through the service website or by telephone.

Appointment slots were 15 minutes. If clinics were to run late then staff told us they would keep those waiting in the waiting room updated. At the time of our inspection we saw that all appointments were running on time.

From January 2019 to January 2020 the service had not had to cancel any appointments.

The service clearly displayed scanning packages that were available and costings for each package both in the clinic and on their website. We saw a clear pricing guide displayed in the reception area.

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 women in the investigation of their complaint.

Window To The Womb franchise had a complaint handling policy. The policy detailed the process of complaints and staff responsibility. The policy was displayed on a board within the clinic.

The registered manager investigated any complaint received through the comment's cards, website or social media. They told us that they reviewed feedback comments daily and contacted women if they had made a negative comment in order to investigate and address their concern.

The registered manager told us that they attempted to deal with concerns at the time to resolve women's concerns. They told us that there were examples where women who had previously made a complaint came back to the service for a scan for subsequent pregnancies as they felt their concerns had been addressed satisfactorily and professionally.

From January 2019 to January 2020 the service received 13 complaints. None of these complaints went through a formal complaints procedure and the clinic manager contacted the complainants and resolved the issue. The main themes were image quality and poor communication. We saw that complaints were followed up and actions taken to address concerns. For example, the regional manager told us that in response to complaints about image quality they had put actions in place to manage women's expectations around image quality.

Complaints were also shared with staff at the pre-shift meeting and during the monthly team meetings.

The complaints procedure and information about how to make a complaint was included on the back of the services feedback forms which were given to women following their scan.

Between January 2019 and January 2020, the service received 736 compliments through social media and feedback cards.

Are diagnostic imaging services well-led?

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 women and staff. They supported staff to develop their skills and take on more senior roles.

The clinic manager was the registered manager supported by a regional manager who had responsibility for the clinics operated by the franchisee.

Good

Diagnostic imaging

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 provider was committed to supporting staff to develop. For example, the registered manager had joined the service as a scan assistant and had been supported by the franchisee to train and develop to take on the role of clinic manager. They told us that they were offering development opportunities to current scan assistants.

The Window To The Womb Ltd franchisor delivered ongoing training to registered managers. This included clinic visits and training events.

There was a twice-yearly national franchise meetings for the franchisees which registered managers were encouraged to attend.

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 which was done 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, dignity, integrity, privacy 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.

Culture

Staff felt respected, supported and valued. They were focused on the needs of women receiving care.

The service promoted equality and diversity in daily work. The service had an open culture where women, their families and staff could raise concerns without fear.

All staff we spoke with told us t they felt supported, respected, and valued. They enjoyed coming to work and were proud to work for the service.

During our inspection we observed good team working between all members of staff including, the managers, the sonographer and scanning assistant. They supported each other and treated each other with mutual respect.

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. They were able to give us an example of an incident where this had been applied.

We saw that staff were passionate in what they did and were really invested in the service they delivered. We observed a very caring culture with staff demonstrating a caring approach to service users and each other. A member of staff told us they loved coming to work and felt privileged to share in a special time for women and their families.

The culture was inclusive, and all service users were treated equally. There was an equality policy in place which included sexual orientation, disability, age, race and religion. A member of staff told us that they were non-judgmental and treated everyone the same to ensure that women and their partners, friends and families had a unique and special experience A member of staff told us that a same sex couple who had used the service posted a recommendation on social media stating that they had been treated equally and were very pleased with the care they had received. Another member of staff gave an example of feedback they received from a young mother who said that she felt that the clinic was the only place where she had not felt judged by staff.

Governance

Leaders operated effective governance processes, throughout the service and with partner

organisations. Managers were clear about their roles and accountabilities and staff had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a clear governance policy in place. 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 registered manager was supported by the regional manager 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 which included monthly local audits, annual audits and peer review audits. Annual compliance audits included premises checks, health and safety, emergency planning, accuracy and completion of scan reports, completion of pre-scan questionnaires, professional registration and staff records. We saw clear actions were identified and agreed with clinics.

The franchisor held monthly manager meetings attended by senior staff across the franchise group. We reviewed meeting minutes and saw that items discussed included performance, complaints, compliments, training and compliance with policies and procedures. There was an action plan for issues discussed and a completion date.

Monthly local team meetings were held at the clinic. Staff discussed compliance with policies and procedures, audit results, complaints, incidents and patient feedback.

Managing risks, 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.

We saw up to date risk assessments for fire, 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 in place 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.

Managing information

The service collected reliable data. Data or notifications were submitted to external organisations as required.

We saw paper and electronic records and scan reports were stored securely. Paper records were in a locked filing cabinet in the reception area. These were removed monthly by the regional manager and stored centrally. Records were retained by the service in line with General Data Protection Regulations (GDPR).

Systems where electronic records were stored were password protected.

The service had an information governance policy in place and all staff had completed information governance training as part of their mandatory training.

Engagement

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

The service used feedback cards to obtain feedback from women and their families. Women were also able to leave reviews on the services website and through social media sites.

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 anomaly found on a scan. They contacted staff at the trust directly and ensured that the woman had an appointment to se the relevant team at the trust.

Staff told us that they were kept informed and felt involved in the business. Information was shared with staff face-to-face informally on a daily basis and via monthly team meetings. Information was also shared with the team via email. The franchise produced a newsletter that was sent out monthly to all Window To The Womb clinics. However, the franchise director told us that they were reviewing the frequency of the letter as there was not always information to share.

The clinic manager told us that they had a good relationship with other Window To The Womb clinic managers and the regional manager and franchisee. They told us that they could go to them for advice and support when required.

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. The franchisor produced in house training videos that were used for additional training and development. These were mainly aimed at sonographers but could be accessed by scan assistants who wanted to learn more.

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 had a display in the waiting error of "not perfect" scan images called the VIP baby board, as part of their programme to manage women's expectations regarding image quality when carrying out a baby scan.

Outstanding practice and areas for improvement

Outstanding practice

- The service provided separate clinics for early pregnancy scans and well-being scans. The displays in the clinic were altered as to what was most appropriate for each clinic. Staff were mindful that there was a higher risk of complications being detected during early pregnancy scans and separating the clinic meant that if a woman received bad news, they did not have to share a waiting area with women who were further along in their pregnancy.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all handwritten reports are clear and legible.
- The provider should ensure that there is a formalised process in place to provide assurance that daily cleaning is completed.
- The provider should ensure that the clinical waste bin located outside the clinic is locked.
- The provider should formally monitor delayed appointment times.
- The provider should consider providing patient leaflets in other languages.