Sussex Baby Scans Ltd

# Window to the Womb - Eastbourne

**Inspection report**

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

## Ratings

| | |
|---|---|
| Overall rating for this location | Good |
| Are services safe? | Good |
| Are services effective? | Inspected but not rated |
| Are services caring? | Outstanding |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Good |

# Summary of findings

## Overall summary

This is our first inspection of the service.

We rated it as good because:

- The service had enough staff to care for women and keep them safe.
- Staff had training in key skills, understood how to protect women from abuse, and managed safety well.
- The service-controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records.
- Staff provided good care to women that was based on continuous improvement and excellence.
- Managers monitored the effectiveness of the service and made sure staff were competent.
- Staff worked well together for the benefit of women, supported them to make decisions about their care and had access to good information.
- Key services were available flexibly.
- Women were truly respected and valued as individuals. Staff empowered them as partners in their care, practically and emotionally.
- The service planned care to meet the needs of people who used the service, took account of women's individual needs, and made it easy for people to give feedback.
- People could access the service when they needed it and did not have to wait too long for a diagnostic procedure.
- Leaders ran services well using reliable information systems and supported staff to develop their skills.
- Staff understood the service's vision and values, and how to apply them in their work.
- Staff felt respected, supported and valued. They were focused on the needs of women who used the service.
- Staff were clear about their roles and accountabilities. The service engaged well with women to plan and manage services and all staff were committed to improving services continually.
- The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care.
- The leadership team actively sought opportunities for improvement.

However:

- Staff did not always lock computer screens when not in use. During our inspection we saw staff leave the scan assistant room with the computer screen unlocked and the ultrasound machine was left on following the clinic finishing for early reassurance scans. This meant the scan image could be seen on the ultrasound screen and television screens placed on the wall.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Diagnostic and screening services** | Good  | We rated it as Good, see the summary above for details. |

# Summary of findings

## Contents

# Summary of this inspection

## Background to Window to the Womb - Eastbourne

Window to the womb is operated by Sussex Baby Scans Limited. The service opened in 2021 and has not been inspected before.

This is a private service and operates under a franchise agreement with Window to the Womb (Franchise) Limited. The service is an independent healthcare provider offering antenatal ultrasound imaging and diagnostic services to self-funding women aged over 16 years of age.

The service provides diagnostic imaging for self-referring women through a range of ultrasound scan examinations during pregnancy. Ultrasound scan packages include early reassurance scans (from six to 15 weeks and six days), gender scans (from 16 weeks), growth and wellbeing scans (from 24 to 40 weeks, pre-birth) and 4D scan packages (from 24 -34 weeks).

Appointments include scan findings and images for keepsake purposes. In the event of possible anomaly detection, women are referred to the local NHS early pregnancy assessment unit or maternity service depending on the stage or gestation of pregnancy.

The clinic was open from early afternoon to evenings Monday, Tuesday and Thursday, Wednesday mornings, all day on Saturdays and every other Sunday. The clinic was closed on Fridays.

The service had a registered manager who was also the franchise owner.

## How we carried out this inspection

We carried out this unannounced inspection using our comprehensive inspection methodology on 26 July 2022.

During the inspection process, the inspection team:

• Spoke with the registered manager, operational manager, sonographer and scanning assistants.

• Spoke with two women.

• Looked at a range of policies, procedures, audit reports and other documents relating to the running of the service.

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

## Outstanding practice

We found the following outstanding practice:

# Summary of this inspection

- The service had instigated women selecting images from home prior to the COVID-19 pandemic. The registered manager had spoken to the franchisor about developing the system and this was developed and rolled out to other franchises.

## Areas for improvement

**Action the service MUST take to improve:**

- The service MUST make sure computer screens are locked when not in use by staff. (Regulation 17)

# Our findings

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Diagnostic and screening services | Good | Inspected but not rated | ☆ Outstanding | Good | Good | Good |
| Overall | Good | Inspected but not rated | ☆ Outstanding | Good | Good | Good |

Good

# Diagnostic and screening services

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

## Are Diagnostic and screening services safe?

Good

### Mandatory training

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

Staff received and kept up to date with their mandatory training. Staff told us they were encouraged and given time to complete their mandatory training through online and face to face training. The service set a target of 100% completion rate for mandatory training. At the time of the inspection all staff had completed their mandatory training and was meeting the target.

The mandatory training was comprehensive and met the needs of women and staff. Mandatory training included a range of topics such as health and safety, equality and diversity, information governance and infection, prevention and control.

Managers monitored mandatory training and alerted staff when they needed to update their training.The operational registered manager monitored mandatory training monthly through their audit programme and alerted staff when they needed to update their training.

Refresher training and updates took place during the team's quarterly staff meetings and staff were given quizzes to complete to determine their understanding of the information given.

All staff we spoke with told us their training was specific to their roles and they were given opportunities to develop further learning. For example, staff had completed chaperone training and the service had put together specific training on information given to women by the miscarriage association.

### 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.**

Staff received training specific for their role on how to recognise and report abuse. All staff were 100% compliant with their safeguarding training. All staff had completed level 2 adults and level 2 children's safeguarding training. The registered manager had completed level 3 adults and level 3 children's safeguarding training. The service had access to staff who are trained in level 4 safeguarding for advice and support, provided by the main franchise.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service current adult safeguarding policy and children's safeguarding policy. The policies outlined various types of abuse. For example, female genital mutilation (FGM), domestic violence and neglect. Staff told us they felt confident to raise concerns to children visiting the clinic with an adult.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was clear guidance on how to report and escalate any identified adult safeguarding concerns. This included the local authority safeguarding adults and children's guidelines. Staff knew where to access the safeguarding policy and had a good knowledge of the information within it.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. The service had a chaperone policy in place and an ultrasound assistant was always in the room with the woman. The service displayed information regarding safeguarding from abuse in the toilet, so women could discreetly access important information.

The clinic offered scans to women over 16 years of age. The services policy state that all young women aged between 16 and 18 years were only scanned if they were accompanied by an appropriate adult and could provide proof of their current age.

### 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 including clinical areas were clean and had suitable furnishings which were clean and well-maintained. There was access to hand sanitisers throughout the clinic and we saw handwashing posters above sinks. Toilets were checked hourly and cleaned as required.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff conducted a deep clean of the clinic at the beginning and end of each day. The clinic also received a deep clean weekly. We viewed cleaning audits and logs and saw they were completed with any actions clearly identified.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were bare below the elbow and we saw staff regularly washing their hands and using the hand sanitising gel regularly.

The sonographer used disposable gloves and wore a disposable apron during all scans. Staff cleaned equipment after each client. Disposable paper roll was used to cover the examination couch, this was changed, and the couch cleaned between each client.

The sonographer cleaned the transvaginal probes in line with *British Medical Ultrasound Society (BMUS)* and manufacturers guidelines. The service used latex free covers for the transvaginal probe, this was to avoid any allergic reactions.

Good

# Diagnostic and screening services

Hand sanitising gel was available throughout the clinic for staff, clients and visitors. Hand hygiene and cleaning audits were conducted which showed 100% compliance.

We reviewed the infection control policy which had been updated to reflect COVID-19 related precautions. Prior to the COVID-19 pandemic the clinic had started to offer clients the opportunity to view scan photographs at home. This option has continued to be offered to women and reduced the amount of people within the clinic at one time.

## Environment and equipment

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

The design of the environment followed national guidance. There was a large bright waiting area which was visibly clean and tidy. Chairs were spaced around the waiting area to enable social distancing for clients to wait for their appointment, including space for anyone they brought along with them.

The clinic had suitable facilities to meet the needs of women and their families. The waiting area had toys available for children accompanying women to play with whilst waiting for their appointment. Staff always told us that children stayed with their parent and were not left alone within in the clinic.

There were two toilets, one was accessible for wheelchairs and had a baby change area. The couch in the scanning room was adjustable and could be lowered and raised for women.

The service had a kitchen area which was accessible by staff only. Substances which met the *Control of Substances Hazardous to Health (COSHH)* regulations in a locked cupboard. Risk assessment were reviewed yearly, and staff trained in the use of these chemicals. COSHH training was part health and safety training, which was mandatory for all staff.

Training on use of the scanning machine was delivered to sonographers new to the service by the franchisors clinical lead. The scanning machine was serviced annually and we saw records showing the most recent service was in February 2022.

All equipment had in date portable appliance testing There was a sign on the door of the scanning room to indicate when the room was in use

Fire extinguishers had been serviced in the last 12 months and there was a fire evacuation policy. Fire alarms were tested monthly and a fire drill completed. every 3 months.

Staff disposed of clinical waste safely. We saw clinical waste in the scanning room was segregated and stored securely before collection.

Waste was secured with a tie and transported to the clinical waste bin. There was a service level agreement with an external waste management company who collected the clinical waste once or twice weekly depending on need.

## Assessing and responding to risk

**Staff completed and updated risk assessments for each woman and removed or minimised risks. Staff knew what to do and acted quickly when there was an emergency.**

Good

# Diagnostic and screening services

All women attending the service completed a pre-scan questionnaire that included pregnancy history and a declaration for women to sign. This declaration gave consent for information to be shared with an NHS care provider if required. It also enabled women to confirm they were receiving appropriate pregnancy care from the NHS.

Women were asked to bring their NHS pregnancy notes to each appointment unless attending for an early pregnancy scan. Sonographers were able to assess women's pregnancy and medical history through the pregnancy notes and see whether NHS appointments had been attended. Women were still able to have a scan if they had forgotten their maternity notes. However, they told women that they might not be able to provide the gender information without the certainty of gestational age.

Staff made sure women understood that the ultrasound scans they provided were in addition to their routine maternity care and advised women who had missed routine scans in the NHS to ensure they were attended.

The sonographer used the *British Medical Ultrasound Society (BMUS) and Society and College of Radiographers (SCoR)* pause and check list to reduce the risk of error. Checks were carried out to correctly identify the woman. The sonographer checked the woman's full name, date of birth and first line of address, as well as any previous imaging the woman had received.

Due to the nature of the service, there was no emergency resuscitation equipment on site. There were clear guidelines for staff to follow if a woman suddenly became unwell whilst attending the clinic and staff could describe the action they would take.

Staff knew about and dealt with any specific risk issues. The service provided clear guidance for sonographers to follow when they found unexpected results during a scan. Staff told us they were sensitive and caring when giving bad news to women and a detailed medical report clearly explaining the scan findings was given to them. Staff followed a referral pathway with the local NHS trust.

The clinic had clear processes and pathways with local NHS providers for staff to follow if any abnormalities were found during an ultrasound scan. We saw evidence that staff made referrals to local early pregnancy units, with the women's permission.

All referrals to the local pregnancy assessment unit were followed up by the registered manager and information was fed back to women.

The service had emergency guidance in place regarding an ectopic pregnancy diagnosis. The guidance also detailed what staff should do if the woman decided to leave the clinic and not wait for an ambulance.

The sonographer had access and support from the franchisor clinical leads such as clinical director and a specialist nurse manager for early scanning, as well as a sonographer within a different location attached to the service. They would peer review scans and offer advice if required. The service also had access to two independent sonographers who worked with the franchisor if further support or guidance was required.

## 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.**

Good

# Diagnostic and screening services

The service had enough staff to keep clients safe. The service employed five scan assistants which included the operational manager and team leader, a full-time sonographer and manager.

Scan assistants had multiple roles such as working on reception, managing enquiries and assisting the sonographer in the ultrasound room. All bookings were made through a central telephone line which was managed by the registered manager.

The operational manager told us the clinic had very low sickness levels. Staffing levels were planned to meet demand on the service. Each clinic as a minimum had a sonographer, a scan assistant and team leader.

## Records

**Staff kept detailed records of women's care and diagnostic procedures. Records were clear, up to date, stored securely and easily available to all staff providing care.**

Women's notes were comprehensive, and all staff could access them easily and records were stored securely. We reviewed five client records and found all had been fully completed.

The clinic used an electronic records system to store pre-scan questionnaires, referrals to NHS services and completed well-being scan documents.

The pre-scan questionnaire was comprehensive and contained details about the woman's NHS details, reason for appointment and medical history, such as number of previous pregnancies and births, caesareans, miscarriages, ectopic pregnancies. The questionnaire also gathered details of the woman's last menstrual period, first positive test, previous scans and allergies.

GP details were recorded at the point of booking and there was a free text box in the booking questionnaire for any comments the client wanted to make. It was also clearly documented if a referral to NHS services had been made.

The records system could also identify women whose pregnancy was calculated as under six weeks and women booking scans frequently. All women were provided with a copy of their scan report at the end of their scan or were able to access the report via the franchisor app.

## Medicines

The service did not store or administer any medicines to service users.

## Incidents

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

Staff knew what incidents to report and how to report them. The service had an incident reporting policy which covered the reporting and investigation of incidents. There was an incident reporting log and a process for responding to a missed or incorrect diagnosis, and an incorrect gender identification policy.

Good

# Diagnostic and screening services

Staff understood duty of candour and there was a policy in place. 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 clients (or other relevant persons) of certain "notifiable safety incidents" and provide reasonable support to that person. This is provided for by *regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.* There were no reported incidents requiring duty of candour notifications since the clinic had opened in 2021.

Staff told us they were always open and transparent with women and their families and gave examples of when they would give a full explanation to clients.

Staff raised concerns and knew how to report incidents and near misses in line with the service's policy. The service had not reported any clinical incidents at the time of our inspection. However, staff could explain how they would report an incident to either the registered manager or operational manager.

Managers demonstrated a clear knowledge of reporting, investigating and sharing lessons learned. The operational manager gave examples of how incidences between franchises were shared by the franchisor for learning purposes and staff learning.

Staff meetings took place on a three-monthly basis. All staff attend the staff meetings to share updates, compliments and complaints and learning. We were told that if there was urgent information to share with the team this would be shared via the team's social media group or a staff meeting would be called.

## Are Diagnostic and screening services effective?

Inspected but not rated

### Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Local policies and protocols had a review date and were found to be up to date. Policies were written for all Window to the Womb franchise clinics by the clinical lead and director of ultrasound centrally by the franchisor.

Policies and guidance were reviewed yearly by the franchisor unless alerts or changes to policy, including updates from the *National Institute for Health and Care Excellence (NICE), the British Medical Ultrasound Society (BMUS)* and the *Society and College of Radiographers (SCoR)* were received.

The service subscribed to the BMUS as low as reasonably achievable (ALARA) protocols and displayed this information prominently in the clinic. The clinical lead and director of ultrasound for the franchisor also provided advice to the service and conducted peer reviews and assessments for the sonographers.

The sonographer told us they followed ALARA protocols which meant scan times were kept as short as possible to gain the best results. This meant that sonographers did not scan for longer than 10 minutes and would not do a repeat scan within seven days of the previous scan. As per guidance, the service did not scan women who had received a scan within the previous 14 days and informed them of the risks of frequent scanning. This was checked at the point of booking.

Good

# Diagnostic and screening services

## Nutrition and hydration

The service provided water if required. Staff gave women appropriate information about drinking fluids and attending with a full bladder for transabdominal scans or an empty bladder for transvaginal scans.

## Pain relief

**Staff assessed and monitored women regularly to see if they were in pain.**

During scans we observed the sonographer asked women if they were comfortable or experiencing any pain.

## Patient outcomes

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

The registered manager had overall responsibility for governance, as well as the operational manager.

The service used key performance indicators to monitor performance. This enabled the service to benchmark themselves against other franchised clinics. Data was collected and reported to the franchisor every month to monitor performance.

This included information about the number of ultrasound scans completed including the number of rescans and referrals made to NHS services.

The service had achieved 100% accuracy rate for gender confirmation since opening the service. If the sonographer was not able to confirm the gender of the baby, then the clinic offered a rescan free of charge. This information was displayed in the clinic.

There was a target of 5% or below for the re-scan rate for scans post 16 weeks. In the last 12 months the rate was 6.25% for the 3D and 4D scans, this was due to not gaining a clear view of baby.

Women returned to the clinic following a scan between six to 16 weeks for varying reasons. These were because women had developed the symptoms of miscarriage or the woman's scan had an inconclusive outcome.

The service had referred 27 women over 16 weeks of pregnancy and 85 women under 16 weeks of pregnancy to NHS services over the last 12 months.

Sonographers were part of a peer review process to ensure the accuracy and quality of ultrasound scan images, videos and reports. Sonographers reviewed colleague's scans against internal targets and considered areas for improvement such as scan times and gender or health inaccuracies. These were shared and discussed at monthly review meetings and with the director of ultrasound.

Sonographers also received a clinical review by the franchisor lead sonographer every year. We reviewed these assessments and found them to be detailed with action points that were then discussed with individual sonographers.

## Competent staff

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

Good

# Diagnostic and screening services

Managers supported staff to develop through yearly appraisals. We saw staff who had worked at the clinic for longer than 12 months had an up-to-date appraisal in their staff file. The registered manager provided feedback to staff through appraisals. This included feedback on complaints, women's feedback, performance, compliance with policies and procedures, clinic issues, audit results, staffing and rotas.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Sonographers were required to maintain registration with the Health and Care Professions Council (HCPC) and The Society of Radiographers (SOR) and the American Registry for Diagnostic Medical Sonography (ARDMS) and completed competency checks by the clinical lead.

Managers gave all new staff a full induction tailored to their role before they started work.

The clinical lead worked with scan assistants to help them upskill in medical terminology for supporting early pregnancy scans.

Managers gave all new staff a full induction tailored to their role before they started work. We reviewed the induction checklist for a new starter and saw it was comprehensive and fully completed. Staff told us they received a two-week induction which included a shadowing period.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

## Multidisciplinary working

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

The clinic had well-established relationships with local NHS services, including early pregnancy units, midwives and GP. Sonographers used referral pathways to ensure women received timely on-going care, such as when they identified foetal deformities or a miscarriage. Sonographers documented all instances of referrals, including where they made these urgently by phone call.

The clinical lead worked with local NHS services to ensure referral pathways were recognised by their teams and used to improve care and outcomes for women.

## Seven-day services

**Services were available to support timely care.**

The registered manager and operations manager monitored the demand on the clinic and planned opening hours accordingly. The service provided flexible opening times, including evenings and weekends. The service operated six days a week and was closed on Fridays and either open mornings or afternoon and evenings.

Staff provided women and their partners with out of hours contact information of maternity and early pregnancy services at their local NHS hospitals. This meant women always knew who to contact if they needed urgent care.

## Health promotion

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

Good

# Diagnostic and screening services

The service had relevant information promoting healthy lifestyles. The service provided literature within the scan report with advice on COVID-19 and flu vaccinations during pregnancy. Information including maintaining a healthy diet during pregnancy and exercising during pregnancy was also available to women. The scan report also signposted women to advice lines and support groups for parents and mums-to-be to support women to have a healthy pregnancy.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

There was a Mental Capacity Act (2005) policy for staff to follow, which clearly outlined the service's expectations and processes. Staff completed training in relation to consent, and the Mental Capacity Act (2005), as part of their induction and mandatory training programme.

We saw evidence that mental capacity was discussed as a refresher during staff meetings. Staff told us that if they were unsure a woman using the service had capacity then they would speak to the registered manager and the scan would not be carried out. Sonographers we spoke with could give examples of when and how they might assess mental capacity.

Staff gained consent from women for their care and treatment in line with legislation and guidance. This included written and verbal consent. Consent was gained upon arrival when women signed in at reception, using an electronic tablet which included terms and conditions as well as information about their scan. Consent was also gained at various stages throughout the scanning process.

Staff clearly recorded consent within women's records. We observed the sonographer and scan assistant confirming the woman's identity by asking their name and date of birth and checked that they had consented to the scan before they proceeded.

## Are Diagnostic and screening services caring?

Outstanding ☆

### Compassionate care

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

**There was a strong, person-centred culture and staff were highly motivated and inspired to offer care that was kind. Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.**

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way.

Good

# Diagnostic and screening services

Staff we spoke with understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for them. They considered woman's emotional and social needs as being as important as their physical needs. Staff told us they were particularly aware of woman's' mental health needs and anxieties when scanning women who were attending for early pregnancy scan for reassurance.

Staff told us that they would made sure women and their families who had received bad news were given all the time and support they needed. Scan result discussions were held in the scanning room where conversations could not be overheard, and time was given to the woman and their family to ask questions and to go through relevant leaflets and information with staff.

One compliment we saw, spoke of a couples concerns with not being able to get an NHS appointment for reassurance on their pregnancy. However, they were able to be seen at the clinic at short notice and was provided with the required reassurance needed. The compliment said the staff were "caring, professional and able to answer questions easily" and "they provided a full report and gave us all the contact information we needed in any circumstances".

We observed a scan for a woman who was in the stages of early pregnancy and attending for reassurance due to bleeding. We saw staff were compassionate and caring and took their time to explain each stage of the scan. They were able to provide reassurance and took the time to make sure the woman and her partner were fine and understood the information they had been given.

We saw comments and feedback were overwhelmingly positive from women who used the service and their partners. Women thought staff went the extra mile and their care and support exceeded their expectations. Women consistently said staff treated them well and with kindness. Examples of feedback we saw were "Honestly, the best experience, suffering with pregnancy anxiety has been so tough, so we went for a better peace of mind".

"The sonographer always works to get the best angles and images and makes sure they interact with you, your partner and even your baby throughout the whole experience".

"After two miscarriages previously, we were nervous and anxious, we made staff aware of this and they were so lovely and understanding.

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. We observed staff working on reception welcome women and those accompanying them warmly and with compassion. Sonographers introduced themselves and the scan assistant by name when they first greeted people warmly and we could see how this put women and their partners at ease when attending for early pregnancy reassurance scans.

Staff followed policy to keep women's care and treatment confidential. Privacy, dignity and respect training was part of the provider's mandatory requirements for staff and at the time of our inspection all the team were up to date.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs. Sonographers and scan assistants completed training in recognising and managing distress amongst women and their partners.

### Emotional support

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

Good

# Diagnostic and screening services

Staff gave women and those close to them help, emotional support and advice when they needed it.Staff reviewed women's information prior to their scan so that they were aware if women were attending who had a history of miscarriage and anxious, so they could provide extra support and time. Clinics purposely ran at different times to ensure that women who had experienced pregnancy loss or were anxious about their pregnancy were not in a room with women whom were in the later stages of pregnancy.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. Staff gave women and those close to them help, emotional support, and advice when they needed it. All staff were trained in this and sonographers and scan assistants provided emotional support in the event they detected foetal abnormalities or a miscarriage.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff recognised the trauma of a miscarriage and they worked hard to provide support and gain rapid referrals to NHS services.

Sonographers and scan assistants undertook training on having sensitive conversations and breaking bad news. Staff felt confident to have difficult conversations with women and their families when dealing with loss and bereavement. Staff were trained to signpost women and their partners to specialist support services and to access immediate crisis support.

Women were made aware at the point of booking that the sonographer at the clinic was male and were signposted to their other clinic in the franchise if a female sonographer was preferred.

## Understanding and involvement of women and those close to them

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

Staff always empowered women who used the service to have a voice in their care and needs. They showed determination to overcome obstacles to delivering care, such as referring women to local NHS services. Women's individual preferences and needs were always reflected in how care was delivered. Women consistently noted positive communication and sensitivity as one of the aspects of their visit.

Staff made sure women and those close to them understood their care and treatment. They provided clear information about scanning options available and the appropriate time in a pregnancy for these to take place. The service also provided information on its website, through leaflets and posters in the clinic and by referring women to specialist organisations. Women understood when and how they would receive their scan images and results.

Sonographers supported women to make decisions about the next stages of their care. This included onward referral to NHS services when scan results indicated abnormalities or other unexpected results. This ensured women did not leave the clinic without fully understanding where they would receive help and support going forward.

The clinic worked with multiple local NHS hospitals and provided women with a choice of referral hospital if appropriate. Where women lived out of the area, the sonographer spoke with their local NHS hospital to make a referral.

Staff recognised and respected women's needs and supported women to make informed decisions about their care. Staff told us they did not allow partners or family members to translate for women.

Good

# Diagnostic and screening services

Staff told the inspection team that the clinic policy was to ensure each woman attending fully understood all information and was able to make an informed choice when consenting to any scan. For example, a woman whose first language was not English attended the service for an early reassurance scan during our inspection. The woman's partner had initially translated information and consent form for a transvaginal scan and had informed staff that the woman had consented to a transvaginal scan. Due to the service's policy on partners and family not translating for women staff used the translation app and the women chose not to have the transvaginal scan. We were told by staff that this was the perfect example as to why they will only take consent from the women having the scan.

## Are Diagnostic and screening 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.**

Managers planned and organised services, so they met the changing needs of the local population. The service offered a range of ultrasound scan procedures for private fee-paying adults and young people aged 16 to 18 years old. Staff told us they were clear to women that their scans were to complement the NHS maternity pathway through information on the web page and at each scan appointment. Scans available at the service for pregnant women were wellbeing, viability, growth, presentation, 4D and gender scans.

People could easily access services and appointments in a way and at a time that suited them either online or telephone conversation. The registered manager took responsibility for all telephone appointments and queries.

Telephone lines were open Monday to Friday from 8am in the morning until 8.30pm in the evening and 9am in the morning until 5.30pm in the evening on weekends and bank holidays. The service had varied opening hours and operated clinics six days a week including weekends.

Staff told us they always tried to accommodate women, especially those requesting reassurance scans and women told us they had not had to wait to book an appointment and booking was easy.

Facilities and premises were appropriate for the services being delivered. The service had a suitable environment for providing scan procedures to women. There was enough capacity in the waiting area to allow for social distancing.

Prior to the COVID-19 pandemic the service had developed the idea for women to view their scan pictures from home so that women could take their time in the comfort of their own home. During the pandemic the franchisor shared this with other franchises. The service has continued to use this system although if women preferred then they could choose their scan pictures prior to leaving.

The scanning room was spacious and provided a suitable and relaxed environment for women and their families whilst maintaining their privacy and dignity. There was seating in the scanning room for accompanying partners or family members.

Good

# Diagnostic and screening services

Women and their families could remain in the scanning room if they received unexpected news, and staff told us they made sure women could take their time. Women told us they did not feel rushed during their appointments and staff told us if the clinic ran over because a woman needed more time to ask questions then this was not a problem.

The booking system sent out automatic reminders ahead of appointments to women and the service offered a grace period for late attendances caused by unforeseen circumstances. Staff offered flexibility in short notice re-booking in some circumstances, such as if the woman or those close to them had to isolate due to COVID-19. The service did not offer deposit refunds for appointments not attended. However, refunds were given if women were unwell on the day of their appointment or if they had miscarriaged their pregnancy.

## 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 directed women to other services where necessary.**

The premises were accessible for people attending the clinic with a disability. The clinic was on the ground floor, there was a lot of space within the reception area and scanning room. The service also had disabled toilet facilities which had plenty of access, as well as a baby changing area.

The service had separate clinic sessions for women going for early pregnancy scans. This ensured that women who were there for reassurance scans, for example those who had suffered previous miscarriages, did not have to share the waiting room or see women who were much later in their pregnancy.

There were always two staff within the scanning room, the scan assistant and sonographer. The service had a male sonographer, and this was made clear to women at the point of booking. If women preferred a female sonographer, they would arrange an appointment at their other Window to the Womb clinic.

The service had developed a translation package which was accessible through an on-line system. This translated pre-completed information out loud, such as what to expect from your scan, if issues arise and alongside free text interpretation. The system could also be used for women who were visually impaired as it could read out loud any information the staff may need to express. Staff translated scan notes, referral to NHS services and leaflets so that women could understand the information clearly. This included supporting women and their partners who were visually or hearing impaired.

Women were sent information in an email about how to prepare for an appointment and what to bring, including their NHS maternity notes. Women had access to a mobile application built by midwives, nurses and sonographers where they could access online pregnancy support 24 hours a day, seven days a week and have their pregnancy queries answered by clinical professionals.

## Access and flow

**People could access the service when they needed it. They received the right care and their results promptly.**

Managers monitored waiting times and made sure women could access services when needed and received treatment within agreed timeframes and national targets.

Good

# Diagnostic and screening services

Women self-referred to the service and scans were arranged by appointment only. Bookings were made through online booking or telephone. The franchise had also developed a secure smart device application which had an appointment facility.

The registered manager monitored waiting times and worked with staff to make sure women did not stay longer than they needed to. Appointments were booked for 10 minutes with a five-minute scanning time, this included time for women to ask the sonographer any questions.

If a referral to NHS was required, the appointment would take longer and the service ensured that women and partners did not feel rushed and there was enough time between appointments to avoid delaying the next appointment.

Printouts and scan reports were produced immediately after the scan and there was plenty of space in the reception area for women and their partners to wait and allowed for a better flow.

Appointment slots were booked so the service had the flexibility to plan in extra slots at the end of each morning and afternoon session if needed. Women could book early pregnancy scans promptly and were also able to book ahead for later scans of 16 weeks' gestation and above.

Staff told us appointments ran on time and staff had enough time for cleaning the scan room. If a sonographer could not obtain a clear image during a scan due to the position of baby, staff encouraged women to take a walk and have a drink and rescan. The appointment structure meant a rescan could take place quickly and kept delays to a minimum.

The service rarely experienced women who did not attend (DNA) their appointment and in most cases', they would call the woman and rearrange another appointment time.

## 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.**

The service had an up-to-date complaints policy, which outlined procedures for accepting, investigating, recording and responding to local, informal and formal complaints about the service.

Staff understood the policy on complaints and knew how to handle them. The service clearly displayed information in the clinic areas on how to make a complaint. We also viewed the complaints policy and saw that it was up to date. Staff we spoke with understood the complaints policy and understood the process of handling complaints.

The service had received two formal complaints. There were no trends in complaints. One complaint was regarding a scan not being fully completed and the other complaint was in relation to the service not completing a diagnostic scan. Both complaints were fully investigated by the registered manager.

Good

# Diagnostic and screening services

## Are Diagnostic and screening 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 registered manager was the director of the business and held overall responsibility for regulatory compliance. They also ran and owned another window to the womb franchise. Both franchises worked closely together.

As well as the registered manager the senior leadership team included an operational manager who oversaw clinical audits, performance, staff training and policy reviews. The operational manager had started working in the service as a scanning assistant and had been supported to develop their skills to progress as a team leader then operational manager.

The registered manager had a clear understanding of the service's performance, challenges, and priorities and was keen to develop and improve the service for a greater experience for women.

Staff felt the registered manager and operational manager were supportive, visible and always approachable. They felt the senior leadership were effective in their role and actively encouraged development. We saw staff worked well together and there were positive working relationships between staff and senior leadership.

Developing staff was important to the service and on starting employment were offered a

structured training plan and supernumerary period. The aim was for staff to build their clinical

knowledge and skills. Scanning assistants within the service had developed into team leaders and operational manager.

The franchisor's clinical lead sonographer and lead midwife closely supported the team and could always be contacted any time for advice. The national franchisor team provided oversight of policies and compliance with national guidance and best practice.

Window to the womb Eastbourne was a franchise to Window to the Womb Limited. The franchisor provided marketing and operational support such as templates for documents, and digital marketing services.

Regular communication took place between the senior leadership team and staff. Senior leadership were visible, and staff felt they were able to raise potential issues or concerns at any time.

### Vision and Strategy

**The service had a vision for what it wanted to achieve and a strategy to turn it into action and the vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.**

Good

# Diagnostic and screening services

There was a clear set of values centred around seven themes. The themes were focus, dignity, integrity, privacy, diversity, safety and staff. Staff knew the values and demonstrated these values daily during their practice.

The service had a strategic business plan which explained the mission, vision and values of the service. The aim was to provide women with easily accessible ultrasound services.

Senior staff told us they were currently working with NHS services to provide a better pathway for referral into NHS services.

## 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 and provided opportunities for career development. The service had an open culture where women, their families and staff could raise concerns without fear.**

During our inspection we saw staff were passionate about their work, there was a warm positive atmosphere and staff spoke of the importance of good teamwork and working together.

Staff we met were very friendly, welcoming, and confident in their role. They spoke positively about what they do and demonstrated pride in their work. We found an inclusive and constructive working culture within the clinic among the senior leadership and scanning staff.

There was an open and honest culture and staff felt confident to talk to the inspection team in front of senior leads. Staff told us they felt well supported by their managers. The senior team were visible and readily available within the service. Staff felt valued and listened too and there was a clear shared goal of providing the best service to women.

Staff were proud to work at the service and spoke highly of the whole team and registered manager. Staff felt able to report any concerns or feedback to their manager.

There was a clear culture for improvement and innovation to best support women using the service. Leaders were keen to listen to staff and develop ideas and sharing this with the franchisor.

## Governance

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service**. Governance processes were clearly embedded in the service and managers were clear about their role within them. Staff had a clear awareness of governance arrangements and knew how to escalate concerns.

Governance processes were in place and the registered manager was knowledgeable and effective in managing governance and ensuring good compliance. We saw evidence of this clearly through staff meeting minutes and during discussion with staff.

The governance policy was clear and outlined the responsibility between the franchisor and franchisee. The policy detailed the requirement for regular audits and the registered manager had overall responsibility for quality monitoring and regularly reporting key performances and audits to the franchisor.

Team meeting minutes showed staff were given updates, refresher training and updated guidance during the team quarterly meetings.

There was a policies and procedures folder available for staff to access electronically and there was also a copy of policies on the front desk available for women and their partners to read. This also included the services values and mission statement.

Staff records were reviewed, and we saw all staff had references, employment history, employment references, disclosure and barring service (DBS) checks had been completed and proof of identification.

Sonographers were registered with the Society of Radiographers. Personnel files were audited bimonthly by the registered manager. The Window to the Womb franchise had medical liability and indemnity insurance which covered all staff working for the organisation.

The registered manager attended quarterly clinical governance meetings with the franchisor and other managers from the different franchises. Meetings included information around infection control, risks around ectopic pregnancies, incidents, updated and new guidance as well as information on new franchises.

### Management of risk, issues and performance

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

The service had arrangements for identifying, recording and managing risks, issues and mitigating actions. The service did not have a risk register; however, risk was discussed and minuted at quarterly staff meetings.

The registered and operational manager reviewed, updated and shared clinical and operational policies and ensured staff were up to date with current practices and information.

There was an audit programme in place which included bimonthly local audits, annual audits and peer review audits. The operational manager conducted monthly audits which covered a check on staff documentation, registration and training. This audit also covered checks on staffs understanding of policies and emergency plans as ensuring maintenance of equipment was up to date.

Annual compliance audits by the franchisor included premises checks, health and safety, emergency planning, accuracy and completion of scan reports, completion of pre-scan questionnaires, professional registration and staff records.

The senior team had plans in place to cope with unexpected events and the service was open throughout the COVID-19 pandemic offering early reassurance scans. The registered manager operated a policy of no lone working which meant no member of staff worked alone within the clinic. This applied to sonographers carrying out scans. The policy was for a scan assistant to always be present when women were undergoing scans.

The registered manager was responsible for overall risk management in the clinic.

### Information Management

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

Good

# Diagnostic and screening services

The service had appropriate and up-to-date policies for managing personal information that were in line with relevant legislation and the requirements of the General Data Protection Regulations (GDPR). Staff received training for information governance and the GDPR Regulations.

There were effective arrangements in place to ensure the confidentiality of client identifiable data was secure. The electronic booking system and customer database were maintained on a secure, cloud based server.

The service had a data protection and retention policy that reflected national guidance. The service retained a copy of the scan report to refer to the information if required and to identify any concerns following the scan.

Staff could access women's records via two computers, one was kept on reception and the other was kept in the scan assistant room away from the client reception area. During our inspection we saw staff leave the scan assistant room with the computer screen unlocked. The door to the room had a sign clearly displayed which stated staff only and the inspection team noted the screen was left unattended for only a short period of time.

We also saw the ultrasound machine was left on following the clinic finishing for early reassurance scans. This meant the scan image could be seen on the ultrasound screen and television screens placed on the wall. The clinic was empty and there were no clients within the building. The image was removed before the next clinic had started.

The mobile application which women could use to access their scan images required a unique access code which was sent to the client in order to gain access.

## Engagement

**Leaders and staff actively and openly engaged with women, staff, equality groups, the public and local organisations to plan and manage services.**

The service used feedback from clients to improve service provision and quality. The service encouraged women to provide feedback through online reviews, social media reviews or email and staff engaged well with women and their partners. The service had a website which provided health information to women.

The registered manager and compliance manager regularly monitored feedback through a variety of social media platforms and email. They adapted the service with ideas discussed during team meetings. Staff told us they were given the opportunity to feel involved in the running of the service and were able to give feedback and suggestions.

## Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**

There was a culture of continuous learning and improvement in the service and a holistic approach to women's care.

The provider made use of technology to gain instant feedback from women and families using QR codes and social media to help the service continuously improve.

Women were offered the option to download a mobile application which allowed them to log in and instantly access to scan pictures that could be easily shared with friends and family. Women could track their pregnancy and it provided them with access to an online pregnancy support service for any pregnancy related queries.

Good

# Diagnostic and screening services

The service had instigated women selecting images from home prior to the COVID-19 pandemic. The registered manager had spoken to the franchisor about developing the system and this was developed at the start of the pandemic.

The registered and operational manager saw a need to provide accessible services to women and their families using the service. The accessibility approach allows the service to provide information in a range on languages or to support clients with visual and hearing impaired with understanding and making an informed choice regarding their scans.

The service has recently developed their own intranet to provide an easily accessible tool for staff. All documents, audits, advice and information are found on the site and staff called the tool ‘life changing’.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>• Staff did not always lock computer screens when not in use. During our inspection we saw staff leave the scan assistant room with the computer screen unlocked and the ultrasound machine was left on following the clinic finishing for early reassurance scans. This meant the scan image could be seen on the ultrasound screen and television screens placed on the wall. |