Window to the Womb -Wolverhampton

Quality Report

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

Ratings

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

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

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

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

Summary of findings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Window to the Womb- Wolverhampton is operated by SPS Retail Services Ltd. The service provides a baby scanning service which includes early pregnancy scans and gender scans. We inspected diagnostic imaging.

We inspected this service using our comprehensive inspection methodology. We carried out a short announced inspection on 14 November 2019. We gave the service two days notice to ensure staff were available and on site.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's 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 rated this service as **Good** overall.

We found good practice in relation to diagnostic imaging:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Services were available six days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs. They provided emotional support to patients and their families.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for appointments.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients to plan and manage services and all staff were committed to improving services continually.

However,

- Not all opportunities to report incidents had occurred.
- Not all records we looked at had been completed fully.
- We did note that the women read and signed the consent form in the waiting room; rather than having this discussion with a clinician or other staff member prior to signing.

Heidi Smoult

Summary of findings

Deputy Chief Inspector of Hospitals Midlands

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	The provision of ultrasound scanning services, which is classified under the diagnostic core service, was the only service provided at Window to the Womb. We rated this service as good overall because it was safe, caring, responsive to people's needs and well-led. Effective was not rated for this service.

Summary of findings

Contents

Good

Window to the womb- Wolverhampton

Services we looked at
Diagnostic imaging

Summary of this inspection

Background to Window to the Womb -Wolverhampton

Window to the Womb- Wolverhampton is operated by SPS Retail Services Ltd. The service opened in 2016. It is a private service in Wolverhampton. This service primarily serves the communities of the local area. It also accepts patient referrals from outside this area.

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

This service provides diagnostic pregnancy ultrasound services to self-funding women, who are more than six weeks pregnant and aged 16 years and above. All ultrasound scans performed at Window to the Womb were in addition to those provided through the NHS. The service was registered with the CQC to undertake the regulated activity of diagnostic and screening procedures.

We have not previously inspected this service.

The service did not use or store any medications.

Our inspection team

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

Information about Window to the Womb -Wolverhampton

The service provides diagnostic imaging service (ultrasound scans) to self-funding pregnant women aged 16 and above across Wolverhampton. The service is single ground floor clinic with direct access from the pavement which is flat to allow wheelchairs and double pushchairs. The service was a stand-alone purpose built diagnostic and screening facility.

Services

All scans start with a wellbeing check. This check looks at the baby's movements, heartbeat, position, and placental position. The service can offer an internal (vagina) scan.

Early pregnancy scans

- Viability scan- 6 weeks to 10+6 weeks
- Dating scan- 8 weeks to 12+6 weeks
- Reassurance scan- 12 weeks to 15+6 weeks
- Bleeding/pain symptoms scan- 6 weeks to 15+6 weeks
- Previous recurrent miscarriage scan- 6 weeks to 15+6 weeks
- Previous ectopic pregnancy- 6 weeks to 15+6 weeks
- Fertility treatment (IVF)- 6 weeks to 15+6 weeks

Growth and presentation scans

- Performed from 26 to 40 weeks gestation.
- This scan also includes the wellbeing check as described above, but it also includes presentation of the baby, head and abdominal circumference measurements, femur length measurements and estimated fetal weight.

Wellbeing scan

- Previously called 'Take a peek scan'.
- Performed from 16 weeks gestation up to 40 weeks gestation.
- The scan confirms whether it is a single/multiple pregnancy, checks the baby's heartbeat, growth and position, and also the position of the placenta.

Wellbeing and gender scans

- Covers the same as the wellbeing scan but also includes gender confirmation.
- Performed from 16 weeks gestation until 22 weeks gestation.

Summary of this inspection

- 99.9% accuracy.

4D baby scans

- Performed from 24 to 34 weeks gestation.

Window to the Womb does not offer anomaly scans. All scans are provided in addition to the NHS scans, they are not a replacement.

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 2016.

The service is open Monday, Tuesday, Thursday and Friday evenings and all day Saturday and Sunday.

At the time of our inspection, there were seven scan assistants who were on zero-hour contracts and six qualified sonographers and a clinic manager.

During the inspection, we visited the registered location in Wolverhampton. We spoke with five staff and six women being scanned and four partners. During our inspection, we reviewed nine sets of patient records.

Activity (September 2018 to September 2019)

In the reporting period the following scans were undertaken

First Scans (6-15 weeks) - 953 scans completed

Window to the womb scans (16 weeks plus) - 2349 scans completed

Gender scans - 1315 scans completed

Track record on safety

- No Never events
- No Clinical incidents
- No serious injuries
- No incidences of healthcare acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- No incidences of healthcare acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- No incidences of healthcare acquired Clostridium difficile (c.diff)
- No incidences of healthcare acquired E-Coli

Services provided at the hospital under service level agreement:

Waste collection

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Good

We rated 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. The service had an annual plan of mandatory training which was split across the year so that different topics were completed on a monthly basis. Staff completed a range of mandatory training through face to face learning and electronic learning. Staff told us they enjoyed the training that was provided and found it useful and relevant to their role.

Staff who were on zero hours contracts were paid for face to face training; but were expected to complete e-learning training in their own time on an unpaid basis.

We saw the staff training log which showed that 95% of mandatory training courses had been completed.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training included scan assistant induction training, chaperone training, safeguarding children and adults (up to level three depending on role), equality and diversity, Mental Capacity Act and basic life support (role dependant).

Managers monitored mandatory training and alerted staff when they needed to update their training. The manager of the service managed the training completion on a monthly basis and reminded staff when they needed to complete training. The franchisor audited training annually as a minimum and noted what actions were needed to ensure staff were compliant with mandatory training.

All registered managers attended an external mandatory training course provided by the Health and Safety Group. This was re-attended annually to ensure they were fully up to date with current legislation and practice.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. All members of staff completed children's and adults safeguarding to level 2. The manager of the service and directors of the franchise were trained to children safeguarding level 3.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff demonstrated a good understanding of safeguarding and were able to provide examples of how they would escalate their concerns if they identified signs of abuse or harm.

Safeguarding policies and pathways were in-date and were accessible to staff. A separate female genital mutilation (FGM) policy provided staff with clear guidance on how to identify and report FGM. Child sexual exploitation (CSE) and FGM was included in safeguarding training.

Good

Diagnostic imaging

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The registered manager was the designated lead for children's and adult safeguarding. The registered manager had completed both adults and children's safeguarding training at level three. They were available during working hours to provide safeguarding advice and support for staff. Additional safeguarding advice was available from the corporate team who had level four safeguarding training and the local authority.

There had been no safeguarding concerns reported to CQC from September 2018 to September 2019.

Cleanliness, infection control and hygiene

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

Areas were clean and had suitable furnishings which were clean and well-maintained. The consulting room used for all scanning had flooring compliant with Health Building Note 00-10. The flooring was easy to clean, not carpeted and continued up the walls as per best practice guidance. All other areas had easy to clean laminate flooring. Staff kept a moist mop in the waiting room which was used to periodically clean the waiting room floor. This was out of the way of women and their families when not in use.

The service generally performed well for cleanliness. The registered manager was the infection, prevention control lead who conducted regular audits and spot checks of cleanliness. The service conducted hand hygiene audits every four months. In August 2019 the service scored excellent for six of the seven categories and good for one category with a clear explanation of how this could be improved by staff for the future.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. All areas of the clinic were visibly clean. We saw cleaning schedules on the back of the clinical room and the toilet. On the day of the inspection staff signed these hourly to confirm checks and necessary cleaning had been completed. Following the shift all areas were cleaned ready for the next day by staff working for the service.

Staff followed infection control principles including the use of personal protective equipment (PPE). During inspection we saw staff were compliant with services uniform policies, which included all staff involved in clinical work to be bare below the elbows and long hair tied up, which followed good infection control practice. The service had an infection prevention and control policy which provided staff with guidance on such things as cleaning and waste control.

The room used for scanning women did not have a built in sink. Instead it had a portable sink/ water fountain which was plumbed in. We observed staff using this to wash their hands.

We observed plentiful supplies of hand gel. Staff used this regularly and in-between patient contacts. Each patient was provided with a cotton towel to use to tuck into their skirt or trousers prior to the scan to avoid jelly being smeared on clothing. Each towel was placed in a wash basket after patient use; and a fresh towel used for each patient. These were washed on site at 60 degrees to kill any bacteria that was present.

Staff used latex free materials where possible to avoid allergic reactions. This included clinical gloves and covers for the transvaginal probe.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. During the inspection we observed the abdominal scanner being cleaned with appropriate cleaning fluid and wipes after each use between patients. Staff cleaned the couch and replaced disposable paper towel couch covers between each patient.

Disposable privacy curtains were in use in the scanning room. We saw the curtain in use at the time of our inspection had last been changed in September 2019 which is within recommended timescales.

There had been no incidences of healthcare acquired infections at the service in the last 12 months.

Environment and equipment

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

The service had suitable facilities to meet the needs of patients' families. The service was a single ground floor

clinic with direct access from the pavement which was flat to allow wheelchairs and double pushchairs. There was one scan room, a reception area, toilet, kitchen, locked utility room and stock room.

Women and their partners and families arrived in the reception area. This was an open area which included the printing station where women and their partners could choose photographs. The waiting area had three large sofas' and many examples of scan pictures at different stages of pregnancy on the walls.

The service provided an area for children accompanying their parents to play in. This comprised a small table and chair set and a selection of books and toys. Guidance for staff about cleaning these was found in the infection prevention and control policy.

Staff displayed a range of items for sale in the waiting room. This included teddy bears in which a recording of a baby's heartbeat could be inserted, photo frames and other souvenir gifts. These were removed from sight during early pregnancy scan sessions so that any parents receiving bad news would not have to see these.

The scanning consultation room was laid out with four chairs for accompanying friends or family. Three large television screens were situated on walls so that both the patient and people accompanying them could easily view scans. These were turned off at an appropriate time if necessary, for example if women wanted a gender reveal scan, but wished to have the outcome in an envelope to take home and open later, rather than find out at the appointment.

Women and their family or friends could use baby changing facilities whilst at the clinic if required.

Staff carried out daily safety checks of specialist equipment. The ultrasound machine's manufacturer regularly maintained and serviced it. We reviewed service records for the equipment, which detailed the maintenance history and service due dates. Staff told us electrical items were safety tested yearly. During the inspection we looked at records which confirmed these checks had taken place.

Due to the nature of the service they did not need a resuscitation trolley, however they did have a sealed and in date first aid box.

Radiators were covered with wooden covers to reduce the risk of women touching these and burning themselves. The patient couch used in the scan room was suitable for bariatric patients. It could hold up to 498 pounds of weight (225 kilograms).

Staff at the service undertook regular fire safety drills. Fire extinguishers were available in specific points through the clinic. The service had a front and rear fire exit.

Staff disposed of clinical waste safely. Staff disposed of their clinical gloves, and if used, the cover for the transvaginal probe after each use and between patients.

The service did not undertake pregnancy tests, or any other diagnostic tests apart from the ultrasound scans. Staff did not take blood from patients. Therefore, no sharps bins were needed at the location.

The service stored cleaning materials locked in a 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. The key was kept at reception.

Assessing and responding to patient risk

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

Staff responded promptly to any sudden deterioration in a patient's health. We observed four scans taking place during our inspection. Staff adhered to the 'Paused and Checked' checklist

devised by the British Medical Ultrasound Society (BMUS) and Society of Radiographers. For example, the woman's identity and consent was confirmed and clear information and instructions were provided, including the potential limitations of the ultrasound scan. The sonographer asked all women to provide their date of birth and to confirm the spelling of their names to confirm identity.

Staff provided an example of when they had identified and supported a deteriorating patient who had fainted at the clinic. Appropriate actions were taken including consideration of urgent medical treatment and contact

with the emergency service 'hear and treat' services. There was always someone on duty who had adult and children first aid qualifications. In the case of an emergency the service would call 999.

There were clear processes and pathways in place to guide staff on what actions to take if the sonographer found unusual findings on the ultrasound scan. Staff directly referred women to local NHS hospital if a problem is identified. For example, if a patient's scan found a 'pregnancy of unknown location' (PUL; Pregnancy of unknown location is defined as the situation when the pregnancy test is positive but there are no signs of intrauterine pregnancy or an extrauterine pregnancy via transvaginal ultra-sonography. It is not always possible to determine the location of the pregnancy in cases of PUL) women were immediately referred to their local NHS early pregnancy unit. Staff telephoned these units and also sent a hard copy referral form including a copy of the woman's scan with any clinical information attached. Staff told us that most women received an appointment following such a referral within one or two working days. If a hospital declined to accept a referral from the service; staff told us they would liaise between the women and the woman's GP to ensure women were seen quickly.

All women received a copy of their scan report, as well as any images and other purchased products. If a patient had been referred to hospital, staff gave them a copy of the referral form; and could also forward this to the patients' GP with their permission.

If staff discovered evidence of an ectopic pregnancy during a scan, they immediately called 999 for an ambulance to transport the patient to hospital. Staff provided a copy of the clinical scan details and the referral to hospital to both the patient and ambulance crews in a sealed envelope to be handed to the receiving hospital.

Staff could also make referrals to women's GP or local hospital for any unusual findings, such as large unexplained cysts.

Staff followed up on referrals made to check how women were. However, any contact made wasn't routinely recorded in patient notes.

There were signs displayed in the reception area offering a chaperone service. Staff were all chaperone trained. Staff we spoke to were aware of their responsibilities as a chaperone.

For young adults aged 16 to 17 years the service would not perform the scan without their pregnancy records and the staff requested that a responsible adult must go with them to the appointment. The service defined a responsible adult as a person over the age of 18 years and a parent, step parent, legal guardian, grandparent or a person who was acting in place of your parent and could reasonably be expected to exercise responsible supervision of them. The service did not scan anyone under the age of 16. If an individual under the age of 16 requested a scan they would be advised to continue their NHS scans.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had seven scan assistants (3.62 WTE) and six sonographers (0.6 WTE) employed to work at the service on zero hour contracts.

The service did not have any staff members working alone on any shifts. The service always had a minimum of two scan assistants on shift and one sonographer. This ensured there was always enough staff to support the women through the journey in the clinic. There was always a shift leader identified if the manager was not on site.

Sonographers and scan assistants were employed on a zero hour basis. They gave their availability to the service manager in advance who then allocated shifts based on this. Clinic appointment were scheduled in advance to ensure the right number of staff were on duty. Staff we spoke to told us this worked well, allowed flexibility and was easy to adapt rotas if required.

Scan assistants were responsible for manning the reception desk, managing enquiries, appointment bookings, supporting the sonographers during the ultrasound scans, and helping the families print their scan images.

Good

Diagnostic imaging

The service had no vacancies at the time of our inspection.

The service had one staff member leave the service and five staff members join the service in the year before our inspection.

The service had no staff sickness from June 2019 to September 2019. If needed to cover unexpected absence, a sonographer would be brought over from another location in the franchise, to prevent the cancellation of a clinic.

The service had no bank and agency staff usage from June 2019 to September 2019.

All staff including sonographers employed by Window to the Womb underwent a local induction over a three-day period which covered all aspects of the service.

All staff had appropriate pre-employment checks, and all staff had received an enhanced Disclosure and Barring Service (DBS) checks. Staff had the relevant qualifications and reference reviews before starting work, and we saw these on staff files we reviewed onsite.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, stored securely and easily available to all staff providing care. However, not all records had been completed fully.

Records were clear, up to date and easily available to all staff providing care. Patient notes were comprehensive and all staff could access them easily.

We reviewed nine sets of patient notes. These contained relevant details to keep women safe. This included the women's name, date of birth, contact details, NHS number, GP details, number of weeks pregnant, any allergies and local hospital/ maternity unit details. However, we noticed in two of the records we looked that hospital and GP details were not recorded. Therefore, we were not assured staff always gathered all the set information such as name of GP in case of deterioration.

A copy of the scan and an obstetrics report completed by the sonographer was attached to each woman's form which contained clearly recorded notes. The type of scans conducted (transvaginal or transabdominal) were recorded; along with how each device was cleaned following use. The notes detailed whether or not a staff chaperone was present during the scan.

Where needed, and with consent, the sonographer would also send a paper copy of the scan report to the woman's GP or another relevant healthcare professionals when making a referral.

Staff saved the ultrasound images onto a memory stick, which they uploaded to Window to The Womb's 'Bumpies' mobile phone application ('app'), which was a free application for the women. The Bumpies app enabled women to have instant access to their scan images and any video recordings made. Once staff uploaded the images they deleted the images from the memory stick.

Upon request of the women and her partner the scan assistants recorded the unborn baby's heartbeat on a small electronic device during the scan. If women chose not to buy the recording it was deleted after 24-hours.

Records were stored securely. The service kept completed service user records securely in locked drawers within the premises. Any electronic records or systems were password protected and access to the ultrasound machine was password protected and restricted to the sonographer and registered manager.

Medicines

The service did not store or administer any medicines.

Incidents

The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. However, not all opportunities to report incidents had occurred.

The service had an up-to-date incident reporting policy which staff could refer to for guidance. The service used a paper-based reporting system, with an accident and

incident log book available for staff to access. The registered manager was responsible for investigating any incidents reported and submitted a monthly return to the franchisor.

Staff reported serious incidents clearly and in line with the services policy. Staff told us they had not needed to report any incidents up to the point of inspection. However, they identified that certain instances, such as a patient who repeatedly fainted, could have been reported so that staff could discuss this and ensure best practise was reviewed and shared with other staff.

There had been no deaths or serious incidents from September 2018 to September 2019.

Staff were aware of the term duty of candour and could explain to us the need to be open and honest with women when incidents occurred. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify the women (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Incidents and lessons learned were shared with the whole team in monthly team meetings. The service received a monthly newsletter which detailed incidents, risks and information about all Window to the Womb franchisees. The registered manager shared the newsletter with all staff and used the information to discuss and learn from at the monthly team meetings.

The service had a printed emergency action plan. This detailed what to do in different emergency situations.

Are diagnostic imaging services effective?

We do not currently rate effective of diagnostic imaging services.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance, Various policies and relevant national guidance documents were displayed in the scanning room for staff and women to view. These included the 'pause and check' guidelines which are designed to act as a ready reminder of the checks that need to be made when any ultrasound examination is undertaken. We saw recommended exposure times per patient were displayed along with a guide to the safe use of diagnostic ultrasound equipment.

Various policies included the chaperone policy and infection prevention and control policy. Referral details for local NHS hospitals were displayed; and guidance for how to manage difficult conversations was available for staff.

The registered manager checked to make sure staff followed guidance. Staff had to sign and date a checklist to confirm they had read policies as part of their induction and when the service updated policies. We saw evidence of these completed checklists.

The clinical lead, a diagnostic sonographer and clinical nurse specialist from the franchise wrote the policies, and the lead sonographer and a consultant in obstetrics and gynaecology reviewed them. They followed national guidance from the Royal College and Society of Radiographers, the foetal abnormality screening programme (FASP) standards, British Medical Ultrasound Society (BMUS) and the National Institute for Health and Care Excellence (NICE). All policies and protocols had a next renewal date, which ensured the service reviewed them in a timely manner.

The Window to the Womb franchisor informed staff of changes to guidance using a newsletter called 'Open Window'. This was sent out when there were significant changes and when there was enough information to put into a newsletter.

The service followed as low as reasonably achievable (ALARA) principles outlined by the British Medical Ultrasound Society (BMUS). The service kept scanning times to a minimum and did not offer scans that lasted longer than 10 minutes.

The service had an audit programme to assure itself of the quality and safety of the clinic. The franchisor completed annual sonographer competency assessments and an annual clinic audit. The registered

manager completed monthly clinic audits. Included in this audit were the signed terms and conditions to ensure staff had requested all women to read and sign the conditions.

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

Nutrition and hydration

Staff gave patients enough to drink to meet their needs.

Staff gave women information on drinking water before a scan to ensure they attended with a full bladder which enabled the sonographer to gain a better view of the unborn baby.

Women could purchase a range of soft drinks and confectionary products from the service. These were kept in a fridge in the waiting room.

Food and drink was not routinely provided due to the nature of the service and the limited amount of time women spent there. However, staff provided tap water for women and their families who wanted this.

Pain relief

Staff assessed and monitored patients regularly to see if they were comfortable.

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

Patient outcomes

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

The registered manager had overall responsibility for governance and quality monitoring. The service used key performance indicators to monitor performance, which were set by the franchisor. This enabled the service to benchmark themselves against other window to the womb 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 the number of referrals made to other healthcare services.

We saw that service activity audit results and patient feedback were discussed at monthly team meetings.

The service had completed 1315 gender scans and had reported the wrong gender for four scans from September 2018 to September 2019. The Window to the Womb franchise reported a 99.9%

accuracy rate for their gender confirmation scans. This figure was based on over 20,000 gender scans completed at the 38 franchised clinics across the UK. The gender accuracy rate for the service was 99.7% which this service was similar.

The service offered a rescan guarantee for when it was not possible for the sonographer to confirm the gender of the baby at the time of the appointment. From September 2018 to September 2019 the service had to rescan 6% of the patients. We saw rescans were completed because fetal position or maternal habitus prevented completion of all wellbeing checks and/or determination of baby gender, at the time of the initial appointment. In most instances, the woman was asked to mobilise for a short period of time at the clinic, or to drink cold fluids, to encourage baby to reposition and enable a clearer image.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff had attended relevant training for their roles and updated skills in line with the policy of the service. The peer review process for sonographers helped identify any additional training needs. We saw reviews were documented and held in staff personnel files.

All sonographers working in the service were registered with the Health and Care Professions Council or the Society of Radiographers. Registration was checked regularly and we saw records showing staff were within their renewal dates.

Good

Diagnostic imaging

Managers gave all new staff a full induction tailored to their role before they started work. Sonographers new to the service were assessed and signed off as competent by the sonography clinical lead. Yearly competency checks were also completed. At the time of the inspection, the sonography clinical lead was not being reviewed or supervised directly themselves but they attended regular network meetings with national leads to keep up to date with developments within sonography.

Managers supported staff to develop through yearly, constructive appraisals of their work. The manager had completed 100% of appraisals for staff who had worked for the service for more than a year. Service managers provided yearly appraisals to staff. Staff told us these were meaningful interactions and enabled discussions about career development. Staff told us that managers were planning to hold appraisals and reviews on a more regular basis such as monthly to ensure staff progress and wellbeing was monitored.

Sonographers peer reviewed each other's scans for quality monitoring. Two clinical leads for the service were available for support. One clinical lead was a sonographer and one was a nurse. The sonographer offered a constant on call service (24 hours a day, seven days per week including when abroad) for advice and second opinions on scans. They had access to the scans from home via a secure internal network.

Managers identified poor staff performance promptly and supported staff to improve. The manager of the service worked with the staff in the unit on a regular basis. They told us that if they identified any areas of poor performance then this would first be managed informally and the staff member supported to improve and would then go down a formal disciplinary route if no improvements in practice were seen.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss women and improve their care. At the beginning of every shift staff held a fire up meeting to discuss the diary of women that day and any issues or concerns. The meeting followed a set agenda which included; any frustrations from the previous days plans, staff allocated roles for the day, the number of scans booked, business targets and an opportunity for staff to ask questions. We observed one in practise and saw that this was used to allocate roles, update on new information and to motivate team members.

During the inspection we saw the team worked well together. We observed positive interactions between all team members including the director of the franchise.

We saw that whilst the sonographer carried out the ultrasound scan, the scan assistant completed the scan report with instruction from the sonographer and both provided a positive response to show their understanding. Both the scan assistant and sonographer communicated appropriate information, within their remit, to women and those who accompanied them.

The service had worked with the local NHS trusts to ensure referral pathways were effective. They also liaised with them to book women follow up appointments when any concerns had been found during the scan. The service had positive communication with most health care professionals when communicating with NHS services to make a referral. The NHS services include hospitals and GP services.

Seven-day services

Key services were available six days a week to support timely patient care.

The service was open Monday, Tuesday, Thursday and Friday evenings and all day Saturday and Sunday. Times and days varied but scans were usually in the evenings and at weekends. If demand increased more appointments would be facilitated

Women and their partners could book appointments online or by telephone at a time to suit them.

Health promotion

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

Sonographers completed 'wellbeing checks' as part of the scan. This included visually checking all parts of the baby to ensure there were no unexpected complications.

Good

Diagnostic imaging

Staff very clearly explained to the women that this did not replace their NHS health checks; and clearly reiterated that the wellbeing check would not pick up any heart defects or other subtler congenital defects.

Sonographers consistently reinforced the importance of attending all NHS antenatal appointments and asked the women about previous appointments they had attended.

There were information leaflets available in the service to advise women and their families on pregnancy specific issues such as keeping healthy. These leaflets were also available on the company website.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. However, we did note that the women read and signed the consent form in the waiting room; rather than having this discussion with a clinician or other staff member prior to signing.

Staff received and kept up to date with training on the Mental Capacity Act. Staff completed training on the Mental Capacity Act. All staff were up to date with this training and were aware of the clinic policies.

All patient records checked clearly documented signed consent to the ultrasound scan procedures. We saw the type of scan (such as gender reveal) was double checked at the start of the appointment. However, we did note that the women read and signed the consent form in the waiting room; rather than having this discussion with a clinician or other staff member prior to signing.

For transvaginal scans, women had to sign the consent form confirming they agreed to the procedure. Staff would also confirm they consented to this procedure before beginning the scan.

Staff told us they had not seen any women who lacked capacity to consent for a scan. However, they understood the concept of capacity to consent; and reported that they would ensure a patient who had a prolonged lack of capacity would bring someone to the appointment. Alternatively, if a patient had fluctuating capacity; they would work to ensure the appointment was held when the patient was more able to provide capacity to consent. If required staff would refer the women back to their GP or midwife for future scans.

Are diagnostic imaging services caring?

Good

We rated caring **good.**

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with the women and those close to them in a respectful and considerate way. Throughout the inspection we observed staff presented as genuinely kind, compassionate and caring. They engaged enthusiastically with women; and clearly had built up relationships when repeat women attended. Staff showed a genuine interest in the progress of womens' pregnancies.

Three television screens which displayed the images were located in the room so that the patient and their visitors were able to view them easily. We observed how the scan assistant and the sonographer took time to speak with the wider family to help their understanding of what they were viewing. They made sure they highlighted areas on the screen to show what they were explaining.

Patients said staff treated them well and with kindness. Women told us they found staff to be pleasant and approachable. One patient feedback we saw was "amazing experience", another said "the atmosphere is so relaxed and calm".

Staff followed policy to keep patient care and treatment confidential. Staff ensured they kept women's privacy and dignity during ultrasounds by using a privacy screen and towel during transvaginal scans**.**

If a patient had received bad news they had the option of going into the kitchen area if they required more time before they left the premises. This area was private and had seating available.

Good

Diagnostic imaging

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff told us how they valued the importance of each patients' wishes within appointments and took time to listen to what women wanted to know. Staff explained that each woman wanted slightly different things such as some women just wanted to see their baby's feet or hands; whereas other women wanted to find out how the baby had grown since their last appointment. We observed staff take the time to listen to women and engage with them to whether such information. Staff also engaged with partners on an equal basis to the women, recognising their importance in the process.

Emotional support

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

Staff supported women and their partners through their ultrasound, ensuring they were well informed and knew what to expect.

Staff informed us that women and their partners remained in the scanning room if the scan showed abnormal results whilst the scan assistant made them a referral to an NHS provider. The woman and their partner could remain in the room for as long as they needed, or go to the kitchen area and were able to exit the clinic via an alternative exit to prevent them having to pass waiting pregnant women.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. All staff working in the service had been trained on the emotional aspects of receiving bad news. Staff had access to information about local miscarriage support groups for women who had experienced this. The franchise had a confidential line for staff to call if they needed to discuss anything that had affected them.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their pregnancy and make decisions about their care.

Staff made sure patients and those close to them understood their care and treatment. The sonographer we observed provided very clear information about every step of the scanning process to the patient and any accompanying people. They fully included the patient in the process and made sure to explain what they were viewing at all times; such as different body parts. The sonographers communicated information in a way that was easy to understand.

Staff discussed the cost of pregnancy ultrasound scans with women when they booked their appointment. This information was also available on the service's website.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. When women or accompanying family or friends had questions, staff answered these openly and fully.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff sought feedback from women and friends or family also in attendance. They did this via a variety of methods including a comments card after each appointment, social media reviews and trust pilot reviews. Customer feedback on comment cards was reviewed daily to quickly identify compliments or complaints.

One example of patient feedback we saw was "had my little boy with us and he enjoyed it so much, he was mesmerized by seeing the baby".

Patients gave positive feedback about the service. Since January 2019 there had been 128 compliments made to the service.

Are diagnostic imaging services responsive?

Good

We rated responsive **good.**

Service delivery to meet the needs of local people

Good

Diagnostic imaging

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.

Managers planned and organised services so they met the changing needs of the local population. Women were able to access clinics after work and at weekends. At the end of the day was particularly popular for expectant mothers wanting early scans around their working time.

Staff told us how they were working to improve relationships between the clinic and local NHS hospital early pregnancy units to streamline the referral process. Actions included contacting local early pregnancy units to explain the service provided from Window to the Womb – Wolverhampton; and to explain why referrals might be made.

Facilities and premises were appropriate for the services being delivered. The scan room was large with ample seating and additional standing room for several guests, and children of all ages were welcome to attend. Baby change facilities were available and there was a children's play area in reception with a range of educational books and toys available.

The service had systems to help care for patients in need of additional support or specialist intervention. Information about services offered at the location were accessible online. The service offered a range of ultrasound scans for pregnant women; such as wellbeing, viability, growth, presentation, and gender scans.

Women were given relevant information about their ultrasound scan when they booked their appointment, such as needing a full bladder. There was also a link to a 'frequently asked questions' section on the service's website.

The service scanned women who were over six weeks pregnant. Staff told us that some women provided false information about the gestation of their pregnancy when booking online to get an earlier scan. If this was discovered, staff explained to women why it was not appropriate to scan before six weeks.

The service provided payment details in a booking confirmation email prior to appointment. Ultrasound scan prices were detailed on the service's website, and we observed staff clearly explaining costs and payment options to women during their appointments.

Women who wanted to find out the gender of their baby outside of the appointment could be given a sealed envelope telling them whether it was a boy or girl. They could also have a box of different coloured balloons.

Meeting people's individual needs

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

The service split the earlier pregnancy scans and the later pregnancy scans. This was to be more sensitive to the fact that there is a higher change of delivering bad news to those under 16 weeks and to avoid them having to see anyone who was heavily pregnant.

The scanning room was located on the ground floor and was accessible to wheelchair users. The scanning room had an adjustable couch and there was a computer and workstation available for women to view their scan pictures. The front desk at the clinic was lowered on one side to enable women using a wheelchair to speak with staff working on reception. The clinic was generally accessible except for the toilet facilities which were not adapted to wheelchair users. As a result, the clinic had created a relationship with a local café on the same street who did have accessible toilet facilities. Therefore, women could use these as an alternative. If this was identified as not suitable before the appointment, staff told us that the Window to the Womb – Birmingham clinic (owned and run by the same registered manager) was fully accessible and would make arrangements for women to visit there if necessary.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff explained how they would support women whose first language was British Sign Language. They reported they could write words and phrases down; and use basic body language to

communicate basic words. Staff provided an example of how they enabled a Deaf partner to 'hear' the sound of their baby's heat beat through letting the partner touch the speakers to feel vibrations.

Staff told us they had never worked with a patient at this location who had a diagnosed learning disability such as Downs Syndrome. However, they showed a general awareness of how to support women with learning disabilities.

The service had information leaflets available in languages spoken by the patients and local community. Staff supported women who did not speak English as a first language. Staff told us that if a woman spoke a language other than English; they used an international search engine to translate key words or asked accompanying friends or family to translate.

The service allocated enough time throughout women's appointments for them to ask any questions they had, and to decide on their favourite scan images. The appointments lasted around 40 minutes, with the ultrasound scan taking around 10 minutes. We saw women were supported throughout their appointments and were not rushed at any point.

Access and flow

People could access the service when they needed it and received the right care promptly. There was no waiting lists at the time of our inspection.

Managers monitored waiting times and made sure patients could access services when needed. At the time of our inspection there was no waiting list. Women could book online via social media, or directly with the clinic. Women told us the booking process was easy.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. There had been two urgent transfers, one in November 2018 and one in May 2019 both for suspected ectopic pregnancies.

Managers and staff worked to make sure patients did not stay longer than they needed to. Appointments were scheduled for 15 minutes. We saw this allowed ample time for patients to receive their scan and ask any questions they wished to. Women had additional time after their appointment to view and select images. We saw that the service was flexible to adjust times where possible if women were early or late.

Managers worked to keep the number of cancelled appointments to a minimum. From September 2018 to September 2019 there had been no cancelled appointments. There had also been no delayed procedures.

Women did not have to wait for scan results. Sonographers completed a wellbeing check of the unborn baby at the start of each ultrasound scan. This was before the gender reveal or the 3D and 4D scan. A report was given at the end of every appointment for the woman to take away with them.

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.

Patients, relatives and carers knew how to complain or raise concerns. Staff provided examples of complaints that had been received. All staff we spoke to knew how to escalate if a complaint was made by a patient whilst still at the clinic.

The service clearly displayed information about how to raise a concern in patient areas. Information on how to make a complaint was also available on the clinic website, and on the reverse of the consent forms and scan reports. 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. The policy confirmed that all complaints should be acknowledged within three working days and resolved within 21 working days.

Managers investigated complaints and identified themes. The service had received three complaints from September 2018 to September 2019. We reviewed one complaint that was a missed opportunity to identify an abnormality in the fetus. The complaint was fully investigated and had a clinical panel review from the franchise. The letter response to the family was thorough and included an apology in line with duty of candour

requirements. The service had supported the individual staff member to improve their practice and had rolled out refresher training for sonographers nationwide to ensure this is not repeated. The service had considered whether this complaint needed to also be recorded as an incident but had fully investigated the complaint so did not need to duplicate the investigation.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff were aware of general themes of complaints, such as appointments taking a little longer when new sonographers were being inducted; and where women weren't happy with their scan images. The service offered one free re-scan for women where it was not possible to get a good quality image. However, we saw this was flexible. On the day of inspection, one patient was attending for their third free re-scan due to being unable to see their baby in previous images.

Are diagnostic imaging services well-led?

Good

We rated well-led **good.**

Leadership

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

The service had a registered manager who was responsible for the running of the service. They were also the owner of the service. They managed a team leader and the scan assistants and sonographers. The registered manager also managed another window to the womb service nearby. The manager demonstrated an awareness of the service's performance, limitations and the challenges it faced. They were also aware of the actions needed to address those challenges.

The service ran under a franchise agreement from Window to the Womb.

All staff we spoke to were very positive about the registered manager and their role within the service. They had met the franchise directors and they told us they were friendly and approachable. The manager worked alongside the staff as a scan assistant when required.

The service supported staff to develop their leadership skills, the service had supported one member of staff to take on additional roles and had developed into the team leader for the service.

Staff told us they felt they were given opportunity to progress within the clinic; and told us of potential forthcoming opportunities to develop their job role.

Vision and strategy

The service had a vision for what it wanted to achieve. The vision was focused on sustainability of services.

The service had clear vision and values which were focused on providing safe, high quality care. The vision and values for the service were consistent with the Window to the Womb Ltd franchise. These were to provide women with a private obstetric ultrasound service in an easily accessible environment. To provide medically relevant ultrasound findings within an obstetric report and to report any suspected abnormalities identified using the pathways established with the local NHS hospitals.

The registered manager told us that it was important the service to provide the highest possible standards of care every time.

The services values centred around seven themes: Focus, Dignity, Integrity, Privacy, Diversity, Safety and Staff. Staff we observed demonstrated these values and all understood the role they had in ensuring that the womens visit exceeded their expectations.

Senior staff at the service we spoke with said that they were looking to provide ultrasound scanning services for NHS providers in the future, which formed part of their strategy moving forward.

The manager had plans to develop the service to support women through their pregnancy by working more closely with charities and by setting up peer support groups. We were told that these were plans for the next year.

Culture

Good

Diagnostic imaging

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

Staff told us they enjoyed working at the clinic; and felt supported to learn and develop within their role. Staff told us there were positive working relationships across the two clinics the manager of the service ran, and staff could work across both locations. Staff told us that friendly competitions between the two clinics were promoted to create an environment of improvement.

Staff treated colleagues, women and their families with equal respect. The service was focussed on the patient experience and safety. Staff working in the service offered womens opportunities to feedback on the service throughout their visit. They also encouraged them to feedback online after their appointment.

Staff told us they could raise any concerns they had with the manager of the service or director of the franchise. This could be done through the daily huddles, team meetings or more informally.

The franchisors had a freedom to raise a concern policy in place and had appointed a 'freedom to speak up guardian'. There was also a confidential phone line for staff to contact should they wish to discuss anything that had affected them at work.

Staff well being was of high importance to the manager of this service. They supported staff to ensure they did not work excessive hours and that they worked the shifts to suit their needs.

Governance

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

The clinic director was responsible for governance within the clinic and the franchisor had oversight of these processes. There were regular audits of activities to ensure standards were upheld within the clinic. The franchisor completed detailed, comprehensive annual audits of processes and standards of service, which provided assurance that overarching policies were followed.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The manager of the clinic held monthly team meetings to which all staff were invited. Topics discussed included training, cleaning reminders, reminders to gather patient feedback and general updates and news. The manager compiled minutes which were shared with staff were unable to attend. Those staff were asked to sign to say they had read and understood the minutes.

The manager and director of the service conducted six monthly board meetings. These meetings discussed the business reports, financial reports and operational matters.

Twice yearly all the window to the womb owners met to discuss updates to the services and share learning and developments.

Staff told us that provider level support was good. Local managers received information from provider level management and clinical leads, which was then cascaded down to staff locally within clinics.

Recruitment processes ensured that all staff underwent appropriate checks as required by Schedule 3 of the Health and Social Care Act 2008 for safer recruitment. We reviewed personnel files which had evidence of people being fit and proper for their roles. Sonographers were registered with the Health Care Professional Council and this was regularly checked. There were two forms of proof of identity and all staff had completed disclosure and barring service criminal record checks.

The franchise held insurance for vicarious liability covering medical malpractice for sonographers in the service. All sonographers maintained their individual professional indemnity insurance.

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.

The service did not have a risk register however, we saw evidence that the registered manager reviewed all risk assessments monthly to ensure they documented any changes or identified new risks. We saw up to date risk assessments for fire, health and safety, legionnaires' disease 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 and the member of staff responsible for monitoring and managing the risk. We saw risk assessments were easily accessible to all staff and all staff had seen them.

The service submitted weekly performance reports to window to the womb so that their performance was managed on an ongoing basis. This data was also used by the franchise to compare the service to other Window to the Womb services. The report detailed the number and type of complaints received, the number of pregnancy ultrasounds scans completed within the month, the number of women rescanned, missed appointments and referrals made to other healthcare services.

Managers made staff aware of any new or updated policies by email. We saw policies were regularly discussed at team meetings and staff were required to confirm they had received and read them. Hard copies of policies were also available in the staff room.

We saw appropriate policies and pathways in place for business continuity and major incident planning. The policies highlighted clear actions staff needed to take in the event of an emergency such as severe weather, staff shortages and extended power loss. This included the contact details of relevant individuals or services for staff to contact in an emergency.

Managing information

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

Staff had access to information about quality and sustainability of the clinic. These details were included in notes from team meetings, emailed to staff and held in paper format within the clinic for staff reference. Audit results were shared with staff and peer review outcomes were discussed with individual staff members. Records were retained securely within staff personnel files.

Women and accompanying visitors were able to select from a range of scan images. The service provided a code to a mobile device 'app' where women and family members or friends could also view and download electronic versions of all images taken.

Scan images were stored on the ultrasound machine; and were sent wirelessly to computers in the wider clinic for viewing and printing. The images were stored for one month on the ultrasound machine before being removed. They were stored for longer on the services back up drives.

The terms and conditions of the service were displayed on the Window to the Womb website. This information was also available when women attended appointments.

Window to the Womb Ltd was registered with the Information Commissioner's Office (ICO), which was in line with The Data Protection (Charges and Information) Regulations (2018). The ICO is the UK's independent authority set up to uphold information rights.

The service was compliant with General Data Protection Regulations (GDPR) 2018. Paper records were stored securely. Electronic screens could not be viewed by unauthorised personnel. Consent was gained from women to store their records and information was not shared without a woman's consent. A secure web application for viewing images was provided following scans.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services.

The service engaged openly with patients. Staff requested feedback from women immediately after their scan to inform of the quality of the service. They also had comment cards to give women and women were encouraged to feedback online.

The service received a monthly newsletter which detailed incidents, risks, new and updated policies and

information about all Window to the Womb franchisees. The registered manager shared the newsletter with all staff and used the information to discuss and learn from at the monthly team meetings.

We saw that women interacted well with the service. Staff had created a 'wall of fame' display at the service which showed 'before' and 'after' photos of parents and their baby; such as a scan picture taken prior to giving birth; and a baby photo taken after giving birth.

The team were able to give feedback on the service at any time to the manager. There were meetings at the beginning and end of each clinic when staff could raise issues or concerns. Staff meetings were held each month during which views were actively sought. The team used a secure social media page to communicate about updates, ideas or learning.

The franchise conducted a staff survey at the start of 2019. Results included; 92% of staff agreed or strongly agreed that their induction training properly prepared them for their job; 100% felt free to raise any concerns and 93% agreed that they had good working relationships in their clinic.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Staff felt encouraged and supported to complete training. The team leader had been promoted from a scanning assistant following an interest in management. Window to the womb Ltd had a management and staff development programme which gave the skills and knowledge to enable staff to progress from being a scanning assistant to running their own Window to the Womb franchise.

Window to the Womb Ltd had developed a mobile phone app to engage with women who had attended the service for a pregnancy ultrasound scan. The app enabled women to share scan images with friends and family. The app enabled women to document and share images of their pregnancy bump and could create a time lapse video of their pregnancy.

Learning was shared by the franchisor at six monthly away days for clinic franchisees/owners. The agenda included learning from CQC inspections across the franchise, updates on protocols and customer analysis with other opportunities.

The service had plans to engage more with the local community and charities to support women throughout their pregnancy and beyond.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The service should consider discussing women's consent forms with them prior to them signing.
- The service should ensure all records are fully completed. (Regulation 17)
- The service should ensure all incidents that occur are reported. (Regulation 17)
- The service should consider having a formal risk register.