WTTW Walsgrave Road Coventry

Quality Report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Not sufficient evidence to rate
Are services caring?	Good
Are services responsive?	Outstanding
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Window to the Womb is owned by Vision Beyond Ltd, and operates under a franchise agreement with Window to the Womb (Franchise) Ltd. The service provides diagnostic pregnancy ultrasound services to self-funding women living in Coventry and surrounding areas including Rugby, Leamington Spa and Stratford Upon Avon.

We inspected this service using our comprehensive inspection methodology. We carried out a short-notice announced inspection on 4 April 2019. We gave staff two working days' notice that we were coming to inspect, to ensure the availability of the registered manager.

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 have not previously inspected this service. We rated it as **Good** overall.

We found areas of good practice:

- The service had a clear vision and strategy for what they wanted to achieve which staff understood and adhered to. Quality and sustainability were the top priorities and the service ethos was to provide the highest possible standards of service and care every time.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff were caring, kind and engaged well with women and their families. Feedback was consistently positive about the kindness and care women received from staff.
- The service assessed and managed risks to women, their babies and families. There were clear processes to guide staff on what actions to take if any concerns were identified during the ultrasound scan.
- The service used current evidence-based guidance and good practice standards to inform the delivery of care and treatment. Staff demonstrated a good understanding of national legislation that affected their practice.
- The service treated concerns and complaints seriously. The registered manager completed thorough investigations and measures were taken to resolve concerns and complaints raised. Learning from complaints was shared with all staff.
- The facilities and premises met the needs of women who used the service. The environment in which the scans were performed was spacious, homely and well arranged. Women were encouraged to make their scan experience a family occasion.
- Managers promoted a positive, open culture that supported and valued staff. Staff were proud to work at the clinic and committed to providing the best possible care and service for women and their families.

We found areas of outstanding practice:

- The service took a proactive approach to understand women's individual needs and preferences. Care was delivered in a way that met those needs and was accessible and promoted equality.

Summary of findings

- Women could access services and appointments in a way and at a time that suited them. Technology was used innovatively to ensure women had timely access to treatment, support and care.
- Window to the Womb had invested in technology and equipment which it used to enhance the delivery of effective care and treatment. The scanning room had three large wall-mounted screens which projected the scan images from the ultrasound machine. This enabled women and their families to view their baby scan more easily from wherever they were sitting. They had also developed a mobile phone application ('app'). The app enabled women to document and share week-by-week images of their pregnancy bump with their family and friends and create a time-lapse video of their pregnancy journey. Any scan image taken during a Window to the Womb appointment was also saved on the app, which allowed women to have instant access to their scan images. Women could also book scan appointments through the app.
- Sonographers had timely access to remote advice and support from the franchisor's clinical lead sonographer if they had any questions or concerns about scan findings. Window to the Womb had also developed a continued professional development platform which sonographers could access to enhance their knowledge and skills.

Nigel Acheson
Deputy Chief Inspector of Hospitals

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, effective, caring, responsive to people's needs and well-led. There were processes for the escalation of unexpected findings during ultrasound scans. Feedback form women and their families was positive. Women could access services and appointments in a way and at a time that suited them. Technology was used innovatively to enhance the delivery of effective care and treatment and meet women's needs. Staff had the appropriate skills, knowledge and experience to provide safe and effective care and treatment.

Summary of findings

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Good

Window to the Womb

Services we looked at
Diagnostic imaging

Summary of this inspection

Background to WTTW Walsgrave Road Coventry

Window to the Womb is a private diagnostic service based in Coventry, Warwickshire. It is owned by Vision Beyond Ltd. Window to the Womb (Franchise) Ltd was established in 2003 and has 38 franchised clinics across the United Kingdom.

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

Window to the Womb in Coventry opened in June 2018 and provides diagnostic pregnancy ultrasound services to self-funding women, from 16 to 40 weeks of pregnancy. The service is available to women aged 18 years and above. However, young women from the age of 16 can also use the service if accompanied by an appropriate adult. All ultrasound scans performed at Window to the Womb are in addition to those provided through the NHS as part of a pregnancy care pathway. The service primarily serves women living in Coventry and surrounding areas including Rugby, Leamington Spa and Stratford Upon Avon. It also accepts women from outside this area.

The service has had a registered manager in post since registering with the Care Quality Commission (CQC) in May 2018.

Our inspection team

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

Information about WTTW Walsgrave Road Coventry

The Window to the Womb clinic is located on the ground floor of a commercial building. Facilities include one scan room, reception area and toilet. The service is registered to provide the following regulated activities:

- Diagnostic and screening procedures.

The service provides ultrasound scans to self-funding pregnant women. The Window to the Womb clinic sees between 30 and 35 women per week and offers the following pregnancy ultrasound scans:

- Wellbeing scan from 16 to 40 weeks of pregnancy.
- Wellbeing and gender confirmation scan from 16 to 22 weeks of pregnancy.
- Growth and presentation scan from 26 to 40 weeks of pregnancy.
- Wellbeing and 4D scan from 24 to 34 weeks of pregnancy.

All women accessing the service self-refer to the clinic and are all seen as private (paying) patients.

The service runs four clinics per week. Standard operational hours are Tuesday and Thursday evenings and Saturday and Sunday mornings.

At the time of our inspection Window to the Womb employed a registered manager and nominated individual (director) who co-owned the service, and five scan assistants and three sonographers on zero-hour contracts.

During our inspection we visited the registered location in Coventry. We spoke with six staff members including the

registered manager, a sonographer, two scan assistants, and the franchise director. We also observed two ultrasound scans, spoke with one woman and their partner and reviewed 27 scan reports.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. We have not previously inspected this service.

Activity (15 June 2018 to 5 January 2019)

- In the reporting period, Window to the Womb performed a total of 586 ultrasound scans. A breakdown of the type of scan is shown below:
  - 19 wellbeing scans
  - 270 gender confirmation scans
  - Six growth and presentation scans
  - 153 4D baby scans
- All women were self-funding.
- In the reporting period, no ultrasound scans were delayed or cancelled due to non-clinical reasons.

Track record on safety (15 June 2018 to 5 January 2019)

- Zero never events
- Zero serious injuries
- Zero clinical incidents
- Three complaints
- The service reported zero incidences of health associated MRSA, Methicillin-sensitive Staphylococcus aureus (MSSA), Clostridium difficile (C.diff), or Escherichia Coli (E-Coli).

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Diagnostic imaging

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

Are diagnostic imaging services safe?

Good

We rated it as **good.**

Mandatory training

- **The service provided mandatory training in key skills to staff and made sure everyone completed it.**
- Staff completed mandatory training in accordance with the Window to the Womb franchisor rolling mandatory training programme. The programme covered key areas such as equality and diversity, health and safety, information governance, fire safety awareness, infection control and safeguarding adults and children. Training was provided through a combination of e-learning modules and face-to-face sessions.
- At the time of our inspection all staff were up-to-date with mandatory training. The registered manager also had a copy of mandatory training courses the sonographers had completed with their substantive NHS employer.
- The registered manager was required to attend an external mandatory training course annually. The course covered basic life support, fire safety awareness, information governance, conflict management, safeguarding adults and children, moving and handling, health and safety, control of substances hazardous to health, equality and diversity, food hygiene and lone working training. The registered manager was booked to attend this course in April 2019.

Safeguarding

- **Staff understood how to protect women who used the service and those who accompanied them from abuse. They had completed training on how to recognise and report abuse and knew how to apply it.**
- The service had clear systems, processes and practices to safeguard children, young people and adults from avoidable harm, abuse and neglect that reflected legislation and local requirements. Safeguarding policies and pathways were in-date and were accessible to staff. They included the contact details for the local authority safeguarding teams, the police, the Care Quality Commission (CQC) and the safeguarding lead for the franchisor.
- Staff we spoke with had not needed to make any safeguarding referrals. However, they had a good understanding of their responsibilities with regards to recognising and reporting potential abuse. They were able to describe the steps they would take if they were concerned about the potential abuse of women who used the service or those accompanying them.
- The service was available to women aged 18 years or above. However, young women from the age of 16 could access the service if they were accompanied by an appropriate adult. Children also frequently attended ultrasound scan appointments with their mother. At the time of our inspection, 100% of staff were compliant with safeguarding adults and children

level two training. This level was appropriate to their role and in line with national guidance (Intercollegiate Document, Adult Safeguarding: Roles and Competencies for Health Care Staff (August 2018); Intercollegiate Document, Safeguarding children and young people: roles and competences for health care staff (March 2014)).

- The registered manager was the designated lead for both adults and children safeguarding. They were available during working hours to provide safeguarding advice and support for staff. They had completed both safeguarding adults and children training at level three, as had the two sonographers who were also registered midwives.
- 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. Staff we spoke with demonstrated an awareness of CSE and FGM and knew how to raise a concern if this was required.
- There had been no safeguarding concerns reported to the CQC in the reporting period, from 15 June 2018 to 5 January 2019.
- Safety was promoted through recruitment procedures and employment checks. Staff had Disclosure and Barring Service (DBS) checks undertaken at the level appropriate to their role. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Cleanliness, infection control and hygiene

- **Infection risk was controlled well, with measures in place to prevent the spread of infection. The equipment and premises were clean.**

- Reliable systems were in place to prevent and protect people from a healthcare-associated infection. The sonographer and scan assistants were 'arms bare below the elbow'. This is an infection prevention and control strategy to prevent the transmission of infection from contaminated clothing and enables healthcare staff to thoroughly wash their hands and wrists. We observed staff washed their hands between each patient contact, in accordance with national guidance (National Institute for Health and Care Excellence (NICE), Infection prevention and control: QS61, quality statement 3 (April 2014)). In January and February 2019, audit results showed hand hygiene compliance was 100%. Handwashing facilities and hand sanitiser gel was available in the scanning room and toilet. Hand sanitiser gel was also available in the reception area for staff, women and visitors to use.
- Clinic staff were responsible for cleaning the premises and equipment. We observed all areas of the service were clean and tidy on the day of our inspection.
- There were effective systems to ensure standards of hygiene and cleanliness were maintained. Daily cleaning checklists were completed to ensure staff adhered to the cleaning schedule. A six-monthly deep clean of the clinic was undertaken. The last deep clean of the clinic took place in December 2018.
- Compliance was monitored by the registered manager. We saw the cleaning checklists for the service were consistently completed and showed the premises and equipment were regularly cleaned. The cleanliness of the clinic, such as toilet, scanning room and reception, was also regularly monitored by staff throughout the clinic's operational hours.
- We saw positive feedback from women regarding the cleanliness of the service. Examples of comments included, "A lovely clean and professional environment", "The clinic was very clean and modern looking", and "Meticulously clean and very well kept, a very professional feel".
- Staff followed best practice guidance for the routine disinfection of ultrasound equipment (European Society of Radiology Ultrasound Working Group, Infection prevention and control in ultrasound – best practice recommendations from the European Society of Radiology Ultrasound Working Group (2017)). The ultrasound transducer was decontaminated with disinfectant wipes between each woman and at the end of each day. The transducer was the only part of the ultrasound equipment that was in contact with women.
- The examination couch was protected with a towelling cover which was removed and washed at the end of each clinic. A clean towel was also used to cover the examination couch during scanning procedures. We observed these were changed between each appointment. The towels and covers were laundered separately from other washing at a minimum temperature of 60°C.

- Cleaning equipment was available and stored securely.
- All staff were compliant with infection control training. The Window to the Womb franchisor required staff to undertake infection control refresher training six-monthly.
- Infection prevention and control (IPC) policies and procedures were available to all staff. They provided guidance on appropriate IPC practice such as the daily cleaning schedule, scan machine cleaning and the disposal of waste.
- A risk assessment for Legionella was completed in May 2018 and identified controls to minimise the risk of Legionnaires' disease. The risk of Legionella was low (Source: Provider Information Request D28). Legionnaires' disease is a severe lung infection caused by Legionella bacteria. People can become infected if they inhale water droplets from a contaminated water source such as air conditioning systems and water dispensers.

Environment and equipment

- **The premises and equipment were suitable for purpose and were well looked after.**
- Emergency equipment was not required on site due to the nature of the service. A first aid kit was available which was in-date.
- The scanning equipment used was appropriate for the ultrasound procedures provided. The manufacturer provided the maintenance and servicing of the ultrasound machine. At the time of our inspection the scanning equipment was still within the manufacturer's warranty.
- The electrical equipment we inspected, which included the examination couch, air conditioning unit, scan equipment and light, had been safety tested within the last 12 months. This was in line with national guidance (Health and Safety Executive, Maintaining portable electric equipment in low-risk environments (September 2013)).
- Waste was handled and disposed of correctly. The service did not generate any clinical waste, due to the nature of the scans provided.
- Fire safety equipment was fit for purpose. The alarm system, and heat and smoke detectors were serviced annually. The fire alarm and smoke detector were tested monthly. Fire extinguishers were accessible, stored correctly and had been serviced within the last 12 months. Fire drills were held at least every six months, with the last carried out in January 2019.
- There was adequate storage for consumables such as ultrasound gel and baby keepsake and souvenir products, such as photo frames and keyrings.

Assessing and responding to patient risk

- **The service assessed and managed risks to women, their babies and families.**
- There were clear processes to guide staff on what actions to take if any concerns were identified during the ultrasound scan. The service's referral pathway was followed if any concerns were detected. Women were referred to the most appropriate healthcare professional, with her consent. For example, if the sonographer detected polyhydramnios (excessive amniotic fluid) they would refer the woman to her local NHS hospital's maternity day assessment or fetal medicine unit. If the sonographer suspected placental abruption (where the placenta separates from the uterus before childbirth) they would summon emergency assistance through 999 and transfer the woman to the local NHS hospital.
- Staff told us they had not needed to refer any women to NHS services because of potential concerns found. However, they could clearly describe what they would do if they needed to. Dedicated referral forms were available to document any referrals made. These included a description of the scan findings, the reason for referral, who the receiving healthcare professional was and what action they were going to take.
- The sonographers could contact the Window to the Womb lead sonographer for advice and support during their clinics. The lead sonographer was employed by the franchisor and was available to review ultrasound scans remotely when needed. Staff told us the lead sonographer responded in a timely manner, as soon as they were able.
- Women were advised to bring their NHS pregnancy records to their ultrasound scan appointment. This

meant sonographers had access to their obstetric and medical history if needed. It also meant they had the contact details for the woman's maternity care provider if a concern was identified.

- Staff advised women about the importance of still attending their NHS pregnancy ultrasound scans and appointments. The sonographers ensured women understood that the ultrasound scans they performed were in addition to those provided as part of their NHS maternity care pathway. This information was also stated in the terms and conditions for the service, which clearly advised women to access all antenatal services made available to them by the NHS.
- Women were told when they needed to seek further help. For example, women were advised to contact their midwife or local maternity unit if their baby's movements were reduced.
- There was clear guidance for staff to follow if a woman or visitor suddenly became unwell while attending the clinic. Staff told us they would telephone 999 for urgent support if an emergency arose on the premises.
- The registered manager, nominated individual and two scan assistants had completed first aid training. The registered manager also completed basic life support (BLS) training annually. The sonographer we spoke with had completed BLS training with their substantive NHS employer. BLS training provides a basic overview of how to manage a person who may have stopped breathing or had a cardiac arrest.
- Staff adhered to the 'Paused and Checked' checklist devised by the British Medical Ultrasound Society (BMUS) and Society of Radiographers. While these checks were not formally documented, we observed the sonographer completed them for each woman they saw. 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 service accepted women who were physically well and could transfer themselves to the couch with little support. The service did not offer emergency tests or treatment.

Staffing

- **The service had enough staff to keep people safe from avoidable harm and abuse and to provide the right care and treatment.**
- At the time of our inspection the service employed five scan assistants on zero-hour contracts. They were responsible for managing enquiries, appointment bookings, supporting the sonographers during ultrasound scan procedures and printing scan images.
- The service also employed three sonographers on zero-hour contracts. They were all experienced radiographers or midwives who had obstetric ultrasound experience and worked substantively within the NHS.
- All staff we spoke with felt that staffing was managed well. The service operated with the registered manager and/or the nominated individual (who was a director and manager), a minimum of two scan assistants and one qualified sonographer on duty per shift. No member of staff was required to work alone.
- Ultrasound clinics were scheduled in advance and the sonographers assigned themselves to clinics which fitted around their permanent employment positions.
- Window to the Womb did not use agency staff. Scan assistants and sonographers would cross-cover between themselves to prevent clinic cancellations, in the event of a staff member going off sick. No clinics had been cancelled due to staff absence since the service opened in June 2018.
- No members of staff had left the service since it opened in June 2018. The registered manager told us they were currently recruiting for a clinic manager, who would have responsibility for the day-to-day running of the service.
- The registered manager monitored staff sickness rates. From 15 June 2018 to 5 January 2019, there had been no staff sickness absences.

Records

- **Staff kept detailed records of women's care and treatment. Records were clear, up-to-date and easily available to staff providing care.**

Good

Diagnostic imaging

- Sufficient information was obtained from women prior to their scan appointment, such as number of weeks of pregnancy and known allergies.
- The sonographer undertaking the ultrasound scan completed the paper scan report during the woman's appointment with the support of the scan assistant. This was given to the woman. A copy of the scan report was also stored at the service, in case they needed to refer to it at any time.
- The sonographer would also send a copy of the scan report to the woman's GP or other relevant healthcare professional when a referral was made, if the woman gave her consent.
- The ultrasound images were saved onto a data storage device which could be purchased by the woman at the end of her appointment. Each woman was also given free access to an application (app) developed by the franchisor. The app enabled women to have instant access to their scan images via their personal computer, smart phone or tablet.
- Scan reports were completed immediately after the scan had taken place, which we observed during our inspection. We reviewed 27 scan reports and found staff recorded all the required information clearly and accurately. Scan reports included the woman's estimated due date, type of ultrasound scan performed, the findings, conclusions and recommendations. For example, the sonographer commented on one scan form that the placenta was covering the cervix and should be rechecked at the woman's NHS 20-week anomaly scan. This finding is not unusual at this gestation but if the placenta was found to be low-lying at 20 weeks, placental position should be rechecked around 32 weeks.

Medicines

- The service did not store, prescribe or administer any medicines.

Incidents

- **The service had processes for reporting, investigating and learning from incidents. Staff understood their roles and responsibilities to raise concerns and report safety incidents.**
- There were arrangements for the reporting, reviewing and investigating of safety incidents and events when things went wrong. 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 we spoke with could describe the process for reporting incidents and provided examples of when they would do this, such as equipment breakdown or information governance breaches.
- From 15 June 2018 to 5 January 2019, the service reported zero incidents (Source: Provider Information Request).
- The service did not report any never events in the months prior to our inspection (Source: Provider Information Request). A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers.
- In accordance with the Serious Incident Framework 2015, the service did not report any serious incidents in the months prior to our inspection (Source: Provider Information Request).
- Staff understood the duty of candour and the need for being open and honest with women and their families if errors occurred. The registered manager could explain the process they would undertake if they needed to implement the duty of candour because of an incident, which was in line with the requirements. However, at the time of our inspection, they had not had any incidents that met the threshold for implementing the duty of candour. 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 patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Good

Diagnostic imaging

- The registered manager understood their responsibility to report any notifiable incidents to the CQC.

Are diagnostic imaging services effective?

Not sufficient evidence to rate

We do not currently rate the effectiveness of diagnostic imaging services.

Evidence-based care and treatment

- **Care and treatment provided was based on national guidance and good practice standards.**
- Policies and protocols were in line with current legislation and national evidence-based guidance from professional organisations, such as the National Institute for Health and Care Excellence (NICE) and the British Medical Ultrasound Society (BMUS).
- Staff demonstrated a good understanding of national legislation that affected their practice.
- The service followed the 'As Low As Reasonably Achievable' (ALARA) principles. This was in line with national guidance (Society and College of Radiographers (SCoR) and British Medical Ultrasound Society (BMUS), Guidelines For Professional Ultrasound Practice (December 2018)). Sonographers completed all ultrasound scans within 10 minutes to help reduce ultrasound patient dose, where possible.
- An audit programme provided assurance of the quality and safety of the service. Peer review audits were undertaken in accordance with recommendations made by the BMUS. Other audits, such as clinic and local compliance audits, were undertaken regularly. They monitored women's experience, cleanliness, health and safety, ultrasound scan reports, equipment, policies and procedures. We saw evidence that actions were taken to improve where indicated.
- All policies and protocols were up-to-date and reviewed in a timely manner. They included details of the author, date of publication and date for review.
- Staff knew how to access policies. They were available electronically. Paper copies were also accessible to staff.
- Technology and equipment was used to enhance the delivery of effective care and treatment. The service utilised up-to-date scanning equipment to provide high-quality ultrasound images. They also had three large wall-mounted screens situated in the scan room which enabled women and their families to view their baby more easily. Women had access to the Window to the Womb mobile phone application (app). The app enabled women to record and share images of their pregnancy 'bump' with their family and friends. They could also create a time-lapse video of their pregnancy journey. Each woman's scan images taken during a Window to the Womb appointment was also saved on the app. This meant women had instant access to their scan images.

Nutrition and hydration

- Women were told they could eat and drink as normal before their scan. Women were told it was useful to drink an extra two glasses of water per day during the week running up to their appointment, and to have a snack or meal a couple of hours before their scan to help improve the quality of the ultrasound image. For women less than 20 weeks of pregnancy and for gender confirmation scans, women were also advised to come with a reasonably full bladder to help ensure the best view of their baby. This information was given to women prior to their appointment and was included in the 'frequently asked questions' on the Window to the Womb's website.
- Food and drink was not routinely provided due to the nature of the service and the limited amount of time women spent there. However, bottled water was available to women and visitors.

Pain relief

- Pain relief was not available because abdominal pregnancy ultrasound scans are generally pain free procedures. Staff checked that women were not in any discomfort during their scan.

Patient outcomes

- **Staff monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other Window to the Womb clinics to learn from them.**

Diagnostic imaging

- The service used key performance indicators (KPIs) to monitor performance. These were set by the franchisor and included number of bookings and rescan rate. This enabled the registered manager to benchmark the clinic's performance against the other 37 franchised Window to the Womb clinics. The franchise director told us the service's performance met their expectations.
- 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%.
- Women were offered a free rescan if the sonographer was unable to confirm the baby's gender during the ultrasound scan. From 15 June 2018 to 5 January 2019, the service performed 15 rescans to confirm the gender of the baby. This equated to 5.5% of all gender determination scans performed.
- The service participated in improvement initiatives to monitor the quality of ultrasound scans performed. The sonographers undertook peer review audits. This meant their ultrasound observations and report quality were reviewed by a peer. The sonographers reviewed each other's work and determined whether they agreed with their ultrasound findings and report quality. This was in line with professional guidance which recommends peer review audits are completed using the ultrasound image and written report (Society and College of Radiographers (SCoR) and British Medical Ultrasound Society (BMUS), Guidelines for Professional Ultrasound Practice (December 2018)). The peer review audit assessed the sonographer's activity, technical knowledge and communication skills, such as their scan room hygiene, accuracy of gender confirmation, knowledge of ALARA principles and their ability to answer questions and concerns. They were rated from a score of one (needs improvement) to a score of five (good). We reviewed a sample of peer review audits and found that no concerns were identified.
- Service activity, audit results and service user feedback were regularly discussed at monthly team meetings.

Competent staff

- **Staff had the skills, knowledge and experience needed for their roles.**
- We reviewed the staff personnel records for the sonographers and scan assistants. They all contained evidence of a recruitment and selection interview, employment history, identification, disclosure and barring service (DBS) checks and one employment reference.
- The sonographers were skilled, competent and experienced to perform the pregnancy ultrasound scans provided. All three sonographers performed obstetric ultrasound scans at local NHS hospitals where they were substantively employed. Two of the sonographers were registered midwives who had completed additional scanning training. The other sonographer was a radiographer. Radiographers are healthcare professionals who specialise in the imaging of human anatomy for the diagnosis and treatment of certain conditions and/or illness.
- Each sonographer's competency was assessed when they first joined the service and then annually, by the lead sonographer for the Window to the Womb franchise. The sonographers' registration, indemnity insurance and revalidation status were checked as part of these assessments. If any concerns were identified, the registered manager was expected to address them immediately and additional training or observation was provided. The staff records we reviewed confirmed that all three sonographers had completed a competency assessment within the last 12 months. Furthermore, they had all undertaken training in the scan equipment used.
- The managers and scan assistants also assessed the sonographers for their quality of customer care and service, standard of communication and overall customer experience. Sonographers received verbal and written feedback and the registered manager ensured any concerns or learning points were immediately addressed. We reviewed three customer care and service audits completed in February and March 2019 and saw no issues were identified.
- The three sonographers employed by the service were registered with an appropriate professional body, such

as the Nursing and Midwifery Council (NMC) and the Health and Care Professionals Council (HCPC). Evidence of their current professional registration was filed in their personnel records.

- All staff underwent an induction programme which included staff roles and responsibilities, and mandatory and role-specific training. Staff accessed their training through the service's electronic training portal. Training records confirmed staff had completed role-specific training.
- Staff were encouraged and given opportunities to develop. For example, the Window to the Womb franchise had produced a range of training videos for sonographers covering obstetric and fetal anomalies such as ectopic pregnancy, triploid syndrome (a condition where a fetus has three copies of every chromosome instead of the normal two) and anencephaly (a condition where the brain or spinal cord of a fetus does not develop properly). The sonographers also had workbooks to complete once they had watched the videos.
- All staff were required to have an annual appraisal which was carried out by the registered manager. No members of staff had received an appraisal because they had been employed by the service for less than 12 months at the time of our inspection.

Multidisciplinary working

- **Staff worked together as a team to benefit women and their families.**
- The service had established pathways to refer women to their GP, midwife or local NHS hospital if any concerns were detected. Staff communicated their referral by telephone and letter. The service used a printed referral template and hand wrote the woman's details and reason for referral. A copy of the scan report and images was attached.
- The management team, sonographers and scan assistants worked together for the benefit of women and their families. We observed positive working relationships promoted a relaxed environment and helped put women and their families at ease.

Seven-day services

- Window to the Womb was not an acute service and did not offer emergency tests or treatment. This meant services did not need to be delivered seven days a week to be effective.

Health promotion

- **Women were given information to help them improve their health, care and wellbeing during pregnancy.**
- The service's website contained health and wellbeing in pregnancy advice, such as keeping healthy during pregnancy, foods to avoid, things to ask your midwife and when to seek medical advice. For example, women were advised to contact their maternity unit immediately if they thought their baby's movements had changed and/or reduced. This was in line with national recommendations (NHS England, Saving Babies' Lives: A care bundle for reducing stillbirth (February 2016)).
- The service provided clear written information that the scanning services they provided were not a substitute for the antenatal care pathway provided by the NHS.

Consent and Mental Capacity Act

- **Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. They understood the importance of gaining consent before performing any ultrasound scan.**
- Women were supported to make informed decisions about the pregnancy ultrasound scans provided by the service. All women received written information to read and sign prior to their scan appointment. This was available in every recognised world language. Information included the terms and conditions, such as scan limitations, consent, prices and use of data. The sonographer discussed the potential risks to the unborn child from the additional use of ultrasound prior to commencing the scan. This enabled women to make an informed decision on whether they wished to proceed with the scan.
- Consent to care and treatment was sought in line with legislation and guidance. Staff checked that women had read, understood and signed the terms and

conditions of the service before any ultrasound scan was performed. The terms and conditions included the recommendation that women access all antenatal services made available to them by the NHS.

- Staff gave women the option of withdrawing their consent and stopping the scan at any time, which we observed during our inspection.
- Staff understood their responsibilities regarding consent including Gillick competence. According to Window to the Womb's terms and conditions, women who used the service must be 18 years of age or older. However, they would see young women between the age of 16 or 17, if they were accompanied by an appropriate adult. Staff told us if they had any concerns about a young person's capacity to consent, they would not proceed with the scan. Gillick competence is concerned with determining a child or young person's capacity to consent to medical treatment without the need for parental permission.
- Staff understood their roles and responsibilities under the Mental Capacity Act (2005). They knew how to support women who lacked the capacity to make decisions about their care. While staff had completed training in relation to the Mental Capacity Act (2005), they told us they had not seen any women who lacked capacity since the service opened in June 2018.
- There was an up-to-date Mental Capacity Act (2005) policy for staff to follow. This clearly outlined the service's expectations and processes for determining whether a person had the capacity to make decisions for themselves.

Are diagnostic imaging services caring?

Good

We rated it as **good.**

Compassionate care

- **Staff cared for women with compassion. Feedback from women and their families confirmed staff treated them well and with kindness.**
- We found staff were very passionate about their roles and were committed to providing woman- and family-centred care.
- We observed staff treating and assisting women and their families in a compassionate manner. The scan assistants and sonographer were very reassuring and interacted with the women and those close to them in a warm, friendly and respectful manner.
- Women's privacy and dignity was maintained during their ultrasound scan. All ultrasound scans were carried out in a private room. This meant that women could speak to staff without being overheard. Women were given a clean towel to use as a cover to help maintain their dignity during their ultrasound scan.
- Feedback was consistently positive about the kindness and care women had received from staff. Service user feedback was obtained through feedback forms. These asked women to rate their experience from one star to five stars for ease of booking their scan, initial welcome by the team, care provided during the scan, hygiene and comfort of the clinic and overall experience. We reviewed nine feedback forms completed in March 2019, all of which rated their experience five stars. One woman wrote, "Amazing experience from a great bunch of staff. Would highly recommend to anyone".
- Women and those close to them could also post reviews of the service on social media platforms. From July 2018 to March 2019, 44 reviews had been posted on an on-line review site, of which 93% rated the service as five stars (excellent). Examples of comments included, "Absolutely lovely team, made the experience so precious", "Absolutely fantastic!", "Friendly and professional staff made it a fantastic experience", and "Just like to say a big thank you to all the staff, they make you feel very welcome as soon as you walk through the door". Women also posted feedback on the service's social media webpage. In April 2019 one woman wrote, "Best place to go for a scan! Very friendly and welcoming staff. We went to find our baby's gender and they truly made this moment magical!" In February 2019 another woman wrote, "The lady completing the ultrasound scan was just fantastic, she made us feel welcome and so

relaxed during the whole scan. Lovely to hear her interacting with our scan as well…The service there is 110%, it's fantastic, more than what you could wish for!"

- From 15 June 2018 to 5 January 2019, the service received 106 compliments (Source: Provider Information Request).

Emotional support

- **Staff provided emotional support to women to minimise their distress.**
- Staff were aware that women attending the service were often feeling nervous and anxious and they provided additional reassurance and support to these women. Staff received training in the emotional aspects of receiving bad news as part of their mandatory training.
- Bereavement counselling was available to women via the franchisor. Staff had not needed to refer any woman to other services for emotional support as they had not identified any potential concerns. If they did identify a potential concern they would communicate this sensitively and would arrange appropriate follow up care.
- Women were provided with written information explaining the ultrasound scan prior to their appointment and were advised of who to contact if there was a concern or issue.

Understanding and involvement of patients and those close to them

- **Staff involved women and those close to them in decisions about their care and treatment.**
- Staff communicated with women and those accompanying them in a way they could understand. We saw that staff adapted the language and terminology they used when performing the scan. They took the time to explain the procedure to ensure women understood.
- Women and their partners felt they were fully involved in their care and had been given the opportunity to ask questions throughout their appointment. The woman we spoke with told us, "Everything was explained clearly, I understood everything and felt comfortable asking questions". Feedback we read also confirmed this. For example, one woman wrote, "My partner and I came for a 16-week gender scan. The scan was very thorough and everything was explained fully." While a partner wrote, "The [sonographer] really explained everything in depth and was very knowledgeable. Would definitely recommend."
- Women were encouraged to make their scan experience a family occasion. Women and their partners could bring a further five people with them to their scan appointment which included children, if they wished.
- 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.

Are diagnostic imaging services responsive?

Outstanding ☆

We rated it as **outstanding.**

Service delivery to meet the needs of local people

- **The services provided were tailored to meet the needs of the population served. The premises and facilities were innovative and met the needs of a range of women who used the service.**
- Women's individual needs and preferences were central to the delivery of tailored services and were delivered in a way to ensure flexibility and choice. The service specialised in providing antenatal scans for women from 16 to 40 weeks of pregnancy. All scans started with a wellbeing check of baby's movement, heartbeat, position and placental position. Scan packages were tailored to suit each woman and their family. Gender confirmation and growth scans were also available. Women who mostly wanted a scan for souvenir purposes could view their baby in 4D as well as 2D. NHS pregnancy scans show a two-dimensional image. A 4D scan enables women to see their baby moving as a 3D image. The service only provided private pregnancy ultrasound scans. They did not undertake any ultrasound imaging on behalf of the NHS or other private providers.

- Women who wanted to find out the gender of their baby outside of their appointment, such as at a gender reveal party with their family and friends, were given a sealed envelope with a note telling them whether they were expecting a boy or a girl.
- The facilities and premises were innovative and met the needs of a range of women who used the service. The scanning room had three large wall-mounted screens which projected the scan images from the ultrasound machine. These screens enabled women and their families to view their baby scan more easily and from anywhere in the room. This was in line with recommendations (Royal College of Radiologists, Standards for the provision of an ultrasound service (December 2014)).
- The environment in which the scans were performed was spacious, homely and well arranged. There was adequate seating available for those accompanying the woman during the scan. Staff dimmed the lights when undertaking a scan to darken the room. This meant scan images could be observed more clearly.
- There was a comfortable waiting area, scan room and toilet with baby changing facilities, which was suitable for people with a disability, for women and those accompanying them.
- The service invited women's children to accompany them throughout their appointment. We saw staff ensured the children felt involved in the scan and explained the images of their baby brother or sister. The waiting area also contained a selection of children's toys.
- Staff gave women relevant information about their ultrasound scan when they booked their appointment. This included whether they needed a full bladder and when was the best gestation for their scan. This information was also included in the 'frequently asked questions' on the service's website.
- The service provided women with information about pricing and scan options before their appointment. The service offered several scan packages such as wellbeing, gender confirmation, growth and presentation and 4D. This information was clearly outlined on the service's website.
- Street parking was available on the road where the clinic was located. The service provided information on parking and travelling to the clinic on its website.

Meeting people's individual needs

- **The service took a proactive approach to understand women's individual needs and preferences. Care was delivered in a way that met those needs, was accessible and promoted equality.**
- Reasonable adjustments were made to ensure people with a physical disability could easily access and use the service. The premises were located on the ground floor of the building with ramp access. There was one toilet which had been adapted to meet the needs of people who had a physical disability. The scanning room contained an adjustable couch which staff used to support women with limited mobility.
- Women received written information to read and sign prior to their scan appointment. This was available in languages other than English. The terms and conditions and other key information was also available on the service's website and could be accessed in any recognised world language. For example, the website contained information about the scan, when to call your maternity unit and advice about some pregnancy conditions such as cleft lip and anencephaly (a serious birth defect, in which a major portion of the brain, skull and scalp are absent).
- The service had access to a web-based spoken interpreting service for non-English speaking women when needed.
- The service provided easy to read and large print information leaflets for women with sight impairment. The service also used an online 'read aloud' function.
- The waiting area had adequate seating for women and those accompanying them. The seating was suitable for very overweight people, as was the examination couch.
- All pregnancy ultrasound scans were undertaken in a private clinic room with lots of space for additional relatives, friends or carers to accompany the woman. Women and their partners were invited to bring up to five additional guests with them.

Good

Diagnostic imaging

- The service was inclusive to all pregnant women and we saw no evidence of any discrimination, including on the grounds of age, disability, pregnancy and maternity status, race, religion or belief, and sexual orientation when making care and treatment decisions.
- The service offered women a range of baby keepsake and souvenir options which could be purchased. This included heartbeat bears, a selection of photo frames, fridge magnets and gender reveal products. Heartbeat bears contained a recording of the unborn baby's heartbeat.

Access and flow

- **Women could access services and appointments in a way and at a time that suited them. Technology was used innovatively to ensure women had timely access to treatment, support and care.**
- The service recognised women often preferred to use the internet or mobile phone applications ('app') to contact the clinic and book appointments. Therefore, women could book their scan appointment through the phone, website, or Window to the Womb's app. All women self-referred to the service.
- The service was flexible. At the time of our inspection four clinics a week were held. Clinic appointments were available from 5.45pm to 6.30pm on Tuesdays, 6pm to 7pm on Thursdays, 10.15am to 1.15pm on Saturdays, and 10am to 11.45am on Sundays. The registered manager told us Sunday clinics had recently been commenced to meet increasing demand.
- At the time of our inspection there was no waiting list or backlog for appointments. From 15 June 2018 to 5 January 2019, the service performed 586 ultrasound scans. Of these, 19 were well-being scans, 270 were gender determination scans, six were growth and presentation scans and 153 were 4D scans.
- During our inspection we observed the scan appointments ran on time. Feedback we read and the woman we spoke with also confirmed this.
- From 15 June 2018 to 5 January 2019, no ultrasound scans were delayed or cancelled for non-clinical reasons (Source: Provider Information Request).
- The service monitored rates of non-attendance. This information was submitted to the franchisor monthly. There was a low rate of non-attendance because the service required a non-refundable deposit payment on appointment booking. From 15 June 2018 to 5 January 2019, data showed that 12 women (2%) did not attend their booked appointment.
- There was no waiting time for scan results. Women were given a written report and access to the Window to the Womb app at the end of their appointment.

Learning from complaints and concerns

- **Concerns and complaints were treated seriously, investigated and measures were taken to resolve them. Improvements were made from complaints received. Lessons learned from complaints were shared with all staff.**
- The service had processes to ensure complaints were dealt with effectively. This included an up-to-date complaints policy. Staff were aware of the complaints process and told us that where possible, informal complaints were resolved immediately. Women and/or those close to them were supported to make a formal written complaint if concerns raised could not be resolved informally. The complaints policy stated all written complaints should be acknowledged within three working days and resolved within 21 days. Women were provided with a detailed written response to their complaint including actions taken to resolve it. Face-to-face meetings were also offered where needed.
- The registered manager had overall responsibility for reviewing and responding to complaints.
- From 15 June 2018 to 28 February 2019, the service received four complaints. We saw all complaints were investigated and closed in a timely manner, in line with the complaints policy. Action was taken in response to complaints received to help improve patient experience and service provision. For example, a baby's gender was accidentally revealed to the parents by a member of staff. In response, staff introduced code words that they used to describe a

male or female baby to reduce the risk of accidentally telling parents who did not wish to know the gender of their baby. They also introduced a disclaimer which advised women that while every effort would be made not to reveal the baby's gender, this may at times occur. The woman was offered a complimentary 4D scan.

- Learning from complaints and feedback was shared with staff. All staff we spoke with were aware of the complaints that had been raised and actions taken to address and improve from them. The directors for the Window to the Womb franchise also shared learning from complaints with registered managers at the biannual franchise meetings.
- Information on how to make a complaint was publicly displayed in the clinic. It was also available on the clinic website and the reverse of the feedback form which all women were asked to complete.
- Window to the Womb's induction programme included a course on customer care and dealing with complaints which all staff had completed.

Are diagnostic imaging services well-led?

Good

We rated it as **good.**

Leadership

- **The registered manager had the skills, experience and integrity needed to run a high-quality sustainable service.**
- The registered manager led the service. They were supported by the nominated individual, who was a director and manager of the business. They both 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.
- A qualified accountant supported the effective running of the clinic. They produced monthly management accounts and annual returns.
- Staff understood the management arrangements and told us they felt very well supported. The sonographers reported to the registered manager for matters related to the clinic and to the lead sonographer for the franchise for any clinical issues. The scan assistants reported to the registered manager. At the time of our inspection the service was actively recruiting for a clinic manager to be responsible for the day-to-day running of the service.
- All staff we spoke with were overwhelmingly positive about the registered manager and franchise directors. They said they were friendly, approachable and very visible. Staff felt confident to raise any concerns they had with them.
- Leadership and management development courses were available to all members of staff. Courses included customer service skills, manager induction, behavioural styles, problem solving, performance appraisals and development plans. The registered manager had completed training in all aspects of operating the business.
- The Window to the Womb franchisor was contractually responsible for providing the registered manager with ongoing training. This was undertaken at clinic visits, training events and the biannual national franchise meetings. The registered manager told us they found these events and meetings very informative and enabled the franchisees to share their knowledge, learning and improvement ideas.

Vision and strategy

- **The service had a clear vision and strategy for what they wanted to achieve, with quality and sustainability as the top priorities.**
- The service had a 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 franchise. The vision was to provide, "High quality, efficient and compassionate care to our customers and their families, through the safe and efficient use of obstetric ultrasound imaging technology". The registered manager told us the ethos for the service was to provide the highest possible standards of service and care every time.
- The values for Window to the Womb underpinned the vision and reflected the priorities for the service. These were:

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- **Focus:** Our primary focus is on customer care and comfort; we are dedicated to delivering this care in a professional and ethical manner.
- **Dignity:**All of our customers will be treated with respect.
  - **Integrity:** All of our customers will be treated honestly and fairly and in a manner that ensures their safety.
  - **Privacy:** All of our customers will be treated in a confidential manner.
  - **Diversity:** We recognise, respect and actively support differences among individuals and demonstrate this philosophy through our employment practices, work practices and protocols.
  - **Safety:** We will ensure we meet our legal and ethical obligations in respect of all health and safety issues within our establishment.
  - **Staff:** All of our sonographers meet our high standards in specialising in 3D/4D baby bonding pregnancy scans and are all HCPC (Health and Care Professions Council) certified.

- The Window to the Womb's statement of purpose, which included the vision, aims and objectives and values for the service, was publicly displayed in the clinic.
- The Window to the Womb franchise had developed 12 aims and objectives to support their vision and what they wanted to achieve. Examples of these included; "We report any suspected abnormalities utilising 'Pathways' we have established with our local NHS hospitals", and "The safety of our customers is our primary concern and we will always put this above all other priorities".
- The registered manager told us they were working towards introducing an early pregnancy scanning service. This service provides early pregnancy scans to women from six weeks gestation. The franchisor was supporting the clinic with this. For example, all sonographers were required to complete a two-day training programme and competency assessment in early pregnancy ultrasound scans before this service was introduced.
- Staff had an understanding of the vision, values and strategy for the service and it was evident they aimed to provide women and their families with the best possible pregnancy scan experience.

Culture

- **Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- All staff we met were welcoming, friendly and helpful. It was evident that staff were proud to work at the clinic and were committed to providing the best possible care and service for women and their families.
- We spoke with six members of staff who all spoke very positively about the culture of the service. Staff felt supported, respected and valued and told us they loved working at the clinic. There was a sense of ownership and pride in the service provided and staff strived for excellence in the quality of women's scan experience.
- We observed staff worked collaboratively and shared responsibility in the delivery of good quality care.
- The service promoted an open and honest culture. This was supported by the franchisor's Freedom to raise a concern policy and the appointment of 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 we spoke with were aware of this provision but none had needed to use it.
- Any complaints or incidents raised had a 'no blame' approach to the investigation. Staff were encouraged to raise any concerns or issues they had. In circumstances where errors had been made or where a woman's experience fell short of what was expected, apologies were always offered to the woman and actions were taken to rectify any issues identified. Staff were aware of the duty of candour regulation but had not had any incidents that met the threshold for implementing the duty of candour.
- The sonographers could contact the franchisor's lead sonographer for advice and support when needed.

Governance

- **The service had governance arrangements to ensure high standards of care were maintained.**
- The registered manager had overall responsibility for governance arrangements and quality monitoring.

This included investigating incidents and responding to complaints. The registered manager was supported by the franchisor and attended biannual national franchise meetings where matters such as clinic compliance, performance, audit and best practice were discussed.

- Staff were clear about their roles and understood what they were accountable for and to whom. Staff reported any governance matters such as complaints or incidents to the registered manager, who would in turn inform the franchisor.
- Separate clinical governance meetings were not held due to the small size of the service. Staff told us that if an incident or complaint was received, this was dealt with immediately and discussed amongst the team. The service could manage effectively in this way because there were few staff working at the clinic and they worked so closely together, which we observed during our inspection.
- Monthly staff meetings were held. We reviewed a sample of meeting minutes that showed governance matters such as feedback and complaints, incidents, policies and pathways, audit results and franchisor news and updates were discussed, as well as business performance and sales matters. The meeting minutes showed staff meetings were well attended by all members of the team, including sonographers.
- There were processes to ensure incidents and complaints were investigated in a timely manner, with lessons learned and improvements made to service provision where indicated. All staff we spoke with were familiar with the complaints that had been reported and could describe improvements that had been made.
- Staff underwent appropriate recruitment checks prior to employment to ensure they had the skills, competence and experience needed for their roles. We reviewed the personnel records for staff and found all required information was available, such as employment reference, photo identification, disclosure and barring service (DBS) checks, full employment history, evidence of qualifications and professional registration.
- The service had medical malpractice insurance. The sonographers also had their own indemnity insurance.

Managing risks, issues and performance

- **Effective arrangements were in place to identify, reduce and eliminate risks, and to cope with both the expected and unexpected.**
- Risk assessments had been completed by the registered manager for identified risks such as fire, health and safety and Legionella. These were completed on a standard template to ensure consistent information was captured. The risk assessments identified who or what was at risk, the hazards and their potential effects, existing control measures in place, the risk rating, whether the risk was adequately controlled and additional control measures needed. We saw most of the risks were graded low and had adequate controls in place to minimise each risk. There was also evidence that the risk assessments had been circulated to all employees and the management team. All risk assessments were reviewed annually or sooner if indicated.
- Staff demonstrated knowledge of the main risks to the service and actions in place to minimise them.
- There were appropriate policies and pathways in place regarding business continuity and major incident planning, which outlined clear actions staff needed to take in the event of extended power loss, a fire emergency, adverse weather, staff sickness and sonographer absence. These also contained the contact details of relevant individuals or 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.
- The service used feedback, complaints and audit results to help identify any necessary improvements needed and to ensure they provided a high-quality, effective service. For example, we saw improvements were made in response to complaints received.
- The registered manager compiled a monthly performance report. This was submitted to the franchisor and included the number of ultrasound scans completed, the number of rescans performed, did not attend rates, the number of referrals made to other healthcare services and complaints received. At

the time of our inspection the service was not yet meeting the franchisor target of 50 scans per week. The performance report showed they completed an average of 32 scans per week, from 4 February to 25 March 2019. However, the registered manager and franchise director told us they planned to build the business slowly to ensure the clinic was operating as it should be. They wanted to make sure women were looked after and received a first-class service before they expanded the business. The franchise director told us the service was meeting their expectations.

- The franchisor conducted a clinic compliance audit in April 2019. This covered all aspects of the service such as cleanliness, equipment, health and safety, infection control, emergency planning, feedback and staff. The clinic was compliant with all aspects of the service audited.

Managing information

- **The service collected, managed and used information well to support its activities, using electronic systems with security safeguards.**
- Women's records and scan reports were easily accessible and were kept secure. Paper records were stored in locked filing cabinets and staff locked computer terminals when not in use. Electronic systems were password protected. This prevented unauthorised people from accessing women's records. Scan reports were retained for a period of 30 days in order that any issues following the scan could be rectified. This information was clearly detailed in the terms and conditions of the service. Scan reports could be reviewed remotely by the lead sonographer to enable timely advice and interpretation of results when needed, to inform patient care.
- Staff were aware of the requirements of managing a woman's personal information in accordance with relevant legislation and regulations (General Data Protection Regulations (2016/679 EU)).
- Window to the Womb 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 had an up-to-date information governance policy which staff could refer to for guidance when needed. All staff had completed information governance training.

Engagement

- **The service engaged well with women and staff to plan and manage appropriate services, and collaborated with partner organisations effectively.**
- People's views and experiences were gathered and acted on to shape and improve service provision. Women who used the service were encouraged to give feedback on the quality of service they received. They were asked to rate their experience from one star to five stars for ease of booking their scan, initial welcome by the team, care provided during the scan, hygiene and comfort of the clinic, and overall experience. We reviewed nine feedback forms and found all women had rated the service as five stars.
- Window to the Womb regularly used social media to engage with the local population and promote their service. Staff told us that most feedback was made via social media platforms. The registered manager received a notification whenever feedback was left on-line and responded accordingly. We were told their average response time was 21 minutes.
- Patient feedback was taken seriously and was used to improve the service. For example, following feedback the service had increased staffing to reflect their expanding service and to increase capacity, adjusted their opening times to suit demand, and replaced furniture to enhance women's comfort and those accompanying them.
- It was evident that staff were engaged in the service from the conversations we had with them and observations made during our inspection. Staff told us they felt well informed and were encouraged to make improvements and develop their knowledge and skills. They told us they would recommend the service to their family and friends.
- Staff told us they had regular team meetings. We saw this in minutes we reviewed. Information was shared with staff in a variety of ways such as face-to-face, email, the staff noticeboard and the franchisor

newsletter entitled 'Open Window'. The newsletter was sent to all franchises every six to eight weeks. It included important updates such as Care Quality Commission (CQC) inspections, new clinic openings, training and policies.

- There was transparency and openness with the franchisor about performance. The registered manager submitted performance data to the franchisor every month such as clinic activity and complaints received.

Learning, continuous improvement and innovation

- **Staff were committed to improving the service by learning from when things went well or wrong, continuing professional development and innovation.**
- We found all staff were committed to continuous improvement and to ensuring women and their families received high standards of service and care every time.
- All staff told us they were encouraged and supported to complete training. This included a management and staff development programme which equipped staff with the skills and knowledge to enable them to progress from the role of scanning assistant to that of running their own Window to the Womb franchise, for example. The franchisor had also developed a continued professional development platform for sonographers. These in-house training videos covered obstetric and fetal anomalies such as ectopic pregnancy, triploid syndrome and anencephaly. One of the franchise directors told us the British Medical Ultrasound Society had asked them for access to this training platform.
- Window to the Womb had developed a mobile phone application ('app') to support and engage with women. The app had been designed following feedback from women who wanted to be able to share their scan images with friends and family. The app enabled women to document and share week-by-week images of their pregnancy bump with their family and friends. They could also create a time-lapse video of their pregnancy journey. Any scan image taken during a Window to the Womb appointment was saved on the app. This enabled women instant access to their scan images. Women could also book scan appointments through the app. The franchise director told us the app was now the third most used medical app in the UK.
- We found concerns we raised at the inspection of another Window to the Womb franchise had been addressed by the franchisor and shared with the franchisees. Examples included the introduction of hand hygiene audits and interpretation services.

Outstanding practice and areas for improvement

Outstanding practice

- Window to the Womb had invested in technology and equipment which it used to enhance the delivery of effective care and treatment. The scanning room had three large wall-mounted screens which projected the scan images from the ultrasound machine. This enabled women and their families to view their baby scan more easily, from wherever they were sitting. They had also developed a mobile phone application ('app'). The app enabled women to document and share week-by-week images of their pregnancy bump with their family and friends. They could also create a time-lapse video of their pregnancy journey. Any scan image taken during a Window to the Womb appointment was saved on the app. This allowed women to have instant access to their scan images. Women could also book scan appointments through the app.
- Sonographers had timely access to remote advice and support from the franchisor's clinical lead sonographer if they had any questions or concerns about scan findings. Window to the Womb had also developed a continued professional development platform which sonographers could access to enhance their knowledge and skills.
- In terms of promoting an open and honest culture, the franchisor went above and beyond what was required of an independent healthcare provider. While a freedom to speak up guardian (FTSUG) is a requirement of all NHS organisations, it is not a requirement for independent healthcare providers. However, Window to the Womb had a Freedom to raise a concern policy and had appointed a FTSUG, who was one of the franchise director's. Staff were encouraged and supported to raise a concern about risk, bad practice or wrongdoing that they felt was harming the service. Staff received information on the role of the guardian and how to contact them as part of their mandatory training.