London Scans Limited

Window To The Womb

Inspection report

Unit 2 Broads Foundry
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Overall summary

We rated it as good because:

- 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.
- Staff provided good care and treatment. 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.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- 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 their results.
- 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.

However:

- The quiet room which was used by patients and families who had received unexpected news did not have a door or screen to provide them with sufficient privacy.
- The service should consider reviewing the risk register on a more frequent basis.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Good	Window to the Womb Ealing is owned by London Scans Limited and trades as Window to the Womb. It is part of a national franchise. The service provides antenatal ultrasound imaging and diagnostic services to self-funding or private patients over 16 years of age. The service offers an early pregnancy clinic (from six to 15 weeks of pregnancy), and a later pregnancy clinic (from 16 weeks of pregnancy). Depending on the type of scan performed, these might involve checking the location of the pregnancy, dating of the pregnancy, determination of sex, and fetal presentation at the time of appointment. Patients are provided with ultrasound video or scan images in 2D, 3D or 4D, and an accompanying verbal explanation and written report. The service is registered with the CQC to provide the regulated activity of diagnostic and screening procedures. At the time of our inspection the clinic employed one registered manager, two sonographers and seven scan assistants. In the reporting period January 2021 to May 2022 the service carried out 3400 scans on patients who were 16 to 40 weeks pregnant and 1734 scans on patients from seven to 16 weeks pregnant.

Summary of findings

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Background to Window To The Womb

Window to the Womb Ealing is owned by London Scans Limited and trades as Window to the Womb. It is part of a national franchise.

The service provides antenatal ultrasound imaging and diagnostic services to self-funding or private patients over 16 years of age. The service offers an early pregnancy clinic (from six to 15 weeks of pregnancy), and a later pregnancy clinic (from 16 weeks of pregnancy). Depending on the type of scan performed, these might involve checking the location of the pregnancy, dating of the pregnancy, determination of sex, and fetal presentation at the time of appointment.

Patients are provided with ultrasound video or scan images in 2D, 3D or 4D, and an accompanying verbal explanation and written report.

The service is registered with the CQC to provide the regulated activity of diagnostic and screening procedures.

At the time of our inspection the clinic employed one registered manager, two sonographers and seven scan assistants.

In the reporting period January 2021 to May 2022 the service carried out 3400 scans on patients who were 16 to 40 weeks pregnant and 1734 scans on patients from six to 16 weeks pregnant.

How we carried out this inspection

We carried out a short notice announced comprehensive inspection on 8 June 2022 using our comprehensive methodology.

The inspection team comprised a lead CQC inspector and a specialist advisor. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection for London.

During this inspection, the inspection team spoke with the registered manager, a sonographer, clinic manager and scan assistants including reception staff.

We reviewed 10 patient records which included scan reports and consent forms and staff files.

We observed ultrasound scan procedures with the patient's consent and spoke to patients about their experience of the service. We also reviewed feedback from previous service users.

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

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Summary of this inspection

Action the service SHOULD take to improve:

- The service should consider putting screening in the doorway of the quiet room and making the room more comfortable for patients and families to allow for privacy when they have received unexpected news.
- The service should consider reviewing the risk register on a more frequent basis.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Diagnostic and screening services

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

Are Diagnostic and screening services safe?

Good

We rated safe as 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 which was delivered through a mixture of online modules and face to face training. At the time of our inspection, records we reviewed demonstrated 100% of staff had completed mandatory training. The service had a rolling monthly programme of mandatory training which meant that every month staff would receive training in a different aspect of their mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff.

The service provided us with its training matrix which showed staff received mandatory training in; fire safety and evacuation, mental capacity act, chaperone training, health and safety in healthcare, first aid, equality and diversity, infection prevention and control, safeguarding adults and children, customer care and complaints and information governance. Online modules were provided by the franchisor which included training on sensitive conversations, clinic environment, customer journey, scan outcomes, referral processes, cleaning and hygiene, care and wellbeing of patients, dealing with bereavement and confidentiality. Sonographers also received a video training programme for fetal conditions which was provided by the franchisor.

The registered manager monitored mandatory training and alerted staff when they needed to update their training. They checked training records as part of their bimonthly audit programme.

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 to their role on how to recognise and report abuse. Scan assistants were trained to level 2 safeguarding children and adults and the registered manager and sonographers were trained to level 3.

There was access to level 4 trained staff for advice and support, provided by the franchisor.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

We reviewed the safeguarding policy and saw it was in date and included contact details and a flowchart on how to report safeguarding concerns. The service had a separate female genital mutilation (FGM) policy which provided staff with clear guidance on how to identify and report concerns. Staff we spoke with understood FGM and were aware of what to look for and how to raise concerns.

Staff we spoke with knew how to identify adults and children at risk of, or suffering, harm. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

The service had not had to make any referrals in the last 12 months.

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.

All areas including clinical areas were clean and had suitable furnishings which were clean and well-maintained. There was access to hand sanitisers throughout the clinic and we saw handwashing posters above sinks.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Scan assistants conducted a deep clean of the clinic at the beginning and end of each day. We also observed staff cleaning seating areas and high touch points such as door handles after each patient throughout the day.

We viewed cleaning audits and logs and saw they were appropriately completed with any actions clearly identified. Toilets were checked hourly and cleaned as required.

Staff followed infection control principles including the use of personal protective equipment (PPE) and we saw that staff were bare below the elbow. The sonographer used disposable gloves during scans. They used appropriate covers for the transvaginal probe. We saw that disposable paper towel roll was used to cover the examination couch and this was changed, and the couch cleaned between scans.

Staff cleaned equipment after patient contact. Hand sanitising gel was available throughout the clinic for staff, patients and visitors. We observed appropriate hand washing between patients. We reviewed the most recent hand hygiene audit which showed 100% compliance. Hand hygiene audits were conducted every six months and results were consistently 100% for compliance. The registered manager also told us they conducted random spot checks in between the audits for additional assurance.

We reviewed the infection control policy which had been updated to reflect COVID-19 related precautions. During the pandemic, the service had employed an external cleaning company to carry out additional deep cleans of the clinic as a further precaution to ensure a high standard of cleanliness.

The service ensured patients and visitors could socially distance by allowing one family into the main waiting room at a time. There was a dedicated separate area to wait for scan reports and printouts to ensure social distancing could be maintained at all times.

Good

Diagnostic and screening services

Environment and equipment

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

The service had suitable facilities to meet the needs of patients and their families. There was enough space to enable social distancing between patients and staff. There were two seated waiting areas; one area for patients to wait before their scan and a seating area for patients after their scan while they awaited the printouts of scans.

Training on use of the scanning machine was delivered to sonographers new to the service by the clinical lead of the franchisor. The scanning machine was serviced annually, and we saw records showing the most recent service was in April 2022. The couch in the scanning room was adjustable and could be lowered and raised. There was up to date portable appliance testing with equipment clearly labelled indicating the date of the test. There was a sign on the door of the scanning room to indicate when the room was in use.

Staff disposed of clinical waste safely. We saw appropriate clinical waste management in the scanning room. The provider had a service level agreement with an external waste management company which came regularly to collect clinical waste.

Staff kept substances which met the Control of Substances Hazardous to Health (COSHH) regulations in a locked cupboard in a room accessible by staff only. We saw that these were stored appropriately. A risk assessment was completed and this was repeated every year. Staff were trained in the use of the chemicals used to clean equipment and the premises. COSHH training was part of the health and safety mandatory training.

Assessing and responding to patient risk

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

Staff completed risk assessments for each patient on arrival. Staff completed risk assessments for each patient before attending, on arrival and throughout their stay in the service, using a standard tool.

The service advised all patients to bring their NHS pregnancy notes with them, so sonographers had access to their pregnancy and medical history. Staff told us they called the patient the day before the appointment to remind them to bring their pregnancy notes with them. If a patient did not bring their notes to their 16-week scan, we were told that the scan would not take place and staff would re-book the patient for another appointment so they could bring their notes with them. Staff made sure patients understood that the ultrasound scans they provided were in addition to their routine maternity care and advised patients who had missed routine scans in the NHS to ensure they attended these.

All patients completed a pre-scan questionnaire that included pregnancy history. This included a declaration for patients to sign which gave consent to pass medical information to an NHS care provider if needed and a confirmation that they were receiving appropriate pregnancy care from the NHS.

The service used the ‘Pause and Check’ list devised by the British Medical Ultrasound Society and Society of Radiographers. We saw the sonographer completed the checks during scans, which included confirming the patient’s identity (name, address and date of birth) and consent, providing clear information and instructions, and informing the patient about the results.

Good

Diagnostic and screening services

Staff knew about and dealt with any specific risk issues. They were able to articulate how they would respond promptly to any sudden deterioration in a patient's health. There was a policy in place and staff knew what to do in the event of any sudden deterioration. If a patient was suspected as having an ectopic pregnancy an ambulance was called to transport them to hospital as an emergency. In these cases, the sonographer at the clinic would call the emergency services to ensure that clinical information was properly handed over. The medical emergency policy set out clear instructions for staff on what information to give to the emergency services over the phone and documentation to hand over to the paramedics when they arrived.

The service had clear processes and pathways with local NHS providers for staff to follow if any abnormalities were found on an ultrasound scan.

Staff told us if an abnormality was detected they would make a referral to the local early pregnancy unit, fetal medicine unit or emergency gynaecology department, depending on the stage of pregnancy and with the patient's permission. The service kept dedicated referral forms to use for referrals to different local NHS providers in the area depending on where the patient was registered. If an abnormality was detected the sonographer would give an explanation to the patient and their partner and time would be given for them to ask any questions. The process of the referral into the NHS would be explained so patients would know what to expect and when they would expect to get contacted for an appointment. The patient was also provided with the scan report to take with them to the hospital.

Patients were required to complete a COVID-19 declaration form before attending the clinic.

The registered manager or clinic manager led a huddle at the beginning of each shift to ensure the team were aware of the patients coming in on the day. For example, if there was a patient who was particularly anxious or had a history of miscarriage, staff would be alerted of this to ensure they could provide extra support and time if needed.

We saw that staff explained to patients the importance of attending all NHS scans and appointments and confirmed with them that the scans they carried out were supplementary to their NHS maternity pathway.

The franchisor employed a full-time clinical lead sonographer who could be contacted at any time for second opinion or to confirm the sonographer's initial findings.

The service did scan patients under the age of 18. They carried out scans on patients aged 16-17 years of age and had a policy which outlined that scans could only be requested if patients were accompanied by a parent or guardian and had their pregnancy records with them.

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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave new staff a full induction.

The service had enough staff to keep patients safe. The service employed seven scan assistants on zero-hour contracts. There were three sonographers who were also employed on zero-hour contracts and some also held roles in the NHS.

Scan assistants had multiple roles such as working on reception, managing enquiries and booking appointments, assisting as a chaperone in the ultrasound room and helping families choose and print scan images.

There was always a manager present at each shift and at least two scan assistants. For later pregnancy scans, there would always be three scan assistants on the shift to help manage the flow of the service as these appointments took longer.

The service had also employed a compliance manager to manage staff appraisals.

Managers regularly reviewed and adjusted staffing levels and skill mix, and gave new staff a full induction. The service did not use bank and agency staff. The clinic manager reviewed staffing on a daily basis if there was sickness, they would organise cover and could take the role of scan assistant if needed. In the case of sickness absence, the clinic could call on staff from other clinics run by the franchisor. The service had not had to cancel any appointments due to staffing shortages or sickness in the 12 months preceding our inspection.

The clinic had a lone working policy although staff did not work alone in the clinic.

Records

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

Patient records were comprehensive and all staff could access them easily. Records were stored securely on an electronic system. We reviewed 10 patient records and found all had been fully completed.

The clinic used an electronic records system to store pre-scan questionnaires, referrals to NHS services and completed well-being scan documents. The pre-scan questionnaire was comprehensive and contained details about the patient's NHS details, reason for appointment and patient history, such as number of previous pregnancies and births, caesareans, miscarriages, ectopic pregnancies. The questionnaire also gathered details of the patient's last menstrual period, first positive test, previous scans and allergies. GP details were also recorded at the point of booking. There was also a free text box in the booking questionnaire for any comments the patient wanted to make. We saw that signed consent was also recorded in all records we reviewed. If a referral had been made to an NHS provider, we saw that the referral was also recorded in the notes.

Appointments on the records system were clearly flagged for patients under the age of 18 years; with a pregnancy calculated at under six weeks or over 30 weeks who wanted a 4D scan as it may not have been appropriate to perform scans on these patients. Patients were provided with a copy of their scan report at the end of the scan which contained information on the ultrasound findings, signposting to advice lines and support groups and advice on staying healthy through pregnancy.

When it was necessary to make a referral to the NHS for a patient to receive further advice or treatment, the patient was provided with a full report of the concerns and a referral letter to take with them to the early pregnancy unit or other hospital department so there would be no delays in accessing records. Scan reports could also be shared electronically with the hospital if required. Referrals were arranged by the sonographer before the patient left the clinic wherever possible and the process would be explained to the patient so they knew what to expect when they were seen at the NHS provider.

Patients' personal data and information were kept secure and only authorised staff had access to the information. Staff received training on information governance and records management as part of their mandatory training programme.

Good

Diagnostic and screening services

Medicines

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

Incidents

The service had appropriate processes for staff to raise concerns and report incidents. Staff understood their roles and responsibilities to raise concerns and record safety incidents. Staff were aware of their incident reporting roles and responsibilities. There was an incident reporting policy which explained the process of reporting incidents.

Staff we spoke with knew what incidents to report and how to report them and understood the duty of candour.

The service had an incident reporting policy and an incident reporting log. There was also policy for responding to a missed or incorrect diagnosis, an incorrect gender identification policy and a duty of candour policy.

The clinic kept an incident log and incidents were reviewed and managed by the registered manager. There had been no incidents of moderate harm or above in the last 12 months and no requirement to apply the duty of candour.

Staff attended monthly team meetings to discuss the feedback and look at improvements to a patients' care. The registered manager had access to a 'partners page' on a private social media page where managers of clinics in the franchise could share information and learning from incidents. Incidents were also discussed at the franchisor's clinical governance meetings which took place monthly. Incidents were reviewed and discussed with actions agreed locally or if appropriate, nationally, at these meetings and the registered manager would share learning from incidents that had happened at other clinics within the franchise.

Are Diagnostic and screening services effective?

Inspected but not rated

We do not rate effective for diagnostic services.

Evidence-based care and treatment

The service provided care and procedures based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Local policies and protocols we reviewed were up-to-date and had been written for all Window to the Womb franchise clinics centrally by the franchisor.

They were reviewed by the lead sonographer and a lead midwife who worked for the franchisor and provided advice and conducted peer reviews and assessments for the sonographers.

We reviewed a sample of the clinic's policies including policies for safeguarding adults and children, complaints, scan room safety, fetal abnormality, incorrect gender identification, first aid, chaperone, equality and diversity, infection control, Gillick competence, mental capacity act, information governance, medical emergency, and duty of candour which were all in date and where appropriate, referenced national guidance such as that recommended by the National

Good

Diagnostic and screening services

Institute for Health and Care Excellence (NICE), the Royal College and Society of Radiographers, the foetal abnormality screening programme standards, and the British Medical Ultrasound Society. The franchisor made individual clinics aware when there were changes to guidelines and updated and disseminated updates to policies and procedures including updated training videos.

We reviewed staff records which showed staff had signed to indicate they had read and understood local policies.

Any updates to policies or procedures were discussed at monthly team meetings or at daily huddles. Staff routinely referred to the psychological and emotional needs of patients at morning huddles to ensure staff could support these patients and ensure additional time was spent with them if needed.

The service had an audit programme to assure itself of the quality and safety of the clinic. The registered manager completed bimonthly clinic audits which looked at staff training and documentation, policies, equipment, emergency plans and documentation. The franchisor also completed annual sonographer competency assessments and an annual clinic audit. Sonographer peer reviews took place in line with British Medical Ultrasound Society recommendations.

The service followed the 'as low as reasonably achievable' principles outlined by the Society and College of Radiographers. This meant that sonographers did not scan for longer than 10 minutes and would not do a repeat scan within seven days of the previous scan. As per guidance, the service did not scan patients who had received a scan within the previous 14 days and informed them of the risks of frequent scanning. This was checked at the point of booking.

Nutrition and hydration

Staff took into account patients' individual needs where fluids were necessary for the procedure.

The service reminded patients of the importance of staying hydrated. There was a water dispenser in the clinic for patents to use. Staff also gave appropriate information about drinking water before ultrasound scans to ensure the sonographer can achieve clear scan images.

Pain relief

Staff proactively asked patients about pain and discomfort and would stop scans if the person reported unusual pain. There was a section on the pre-scan consent form which asked patients if they were experiencing pain.

Patient outcomes

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

There was a process in place for the peer review of scan reports to gain assurance that scan procedures were carried out in line with the service's policies. Sonographers carried out peer reviews on colleagues' images every three months to check that the scans had been carried out and reported on correctly.

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

The franchisor's lead sonographer was on call during opening times and could review and give a second opinions on scan images if sonographers had any queries.

The lead midwife for the franchisor also completed yearly audits of the early pregnancy scans and gave feedback to the sonographers.

The service participated in relevant clinical audits within the Window to the Womb franchise. For example, service and care assessment observational audits were conducted every three months for sonographers and scan assistants. This assessed areas such as hand hygiene, customer engagement, communication such as welcomes and introductions, explanation of the scanning room.

Managers shared and made sure staff understood information from the audits. We reviewed monthly meeting minutes which showed discussion around audit results and actions taken.

The service reported a 99.9% accuracy rate for their gender confirmation scans. There was a rescan guarantee in place for when it was not possible for the sonographer to confirm the gender of the baby. The re-scan rate for scans post 16 weeks in the last 12 months was 14%. This was higher than the target of 10%. However, this was tracked weekly and reasons for re-scans were mainly due to the position of the baby. The re-scan rate for 6-16 weeks was 1% which was better than the target of 5%.

The service monitored outcomes for service users and experience, through bimonthly clinic audits carried out by the registered manager and client satisfaction feedback and complaints. The service received mostly positive feedback from patients.

The franchisor carried out a comprehensive compliance audit every year. Areas covered in the audit were a physical clinic inspection, health and safety, infection control, emergency planning, operational delivery, policies and procedures, client feedback and staff including the sonographers. We reviewed the last franchisor clinic compliance audit, carried out in February 2022 which showed that the clinic had been given the highest rating and was fully compliant in all areas.

The service reported that there had been a total of 118 referrals made to NHS services from June 2021 to June 2022 as a result of unexpected findings during scan procedures. Two of these had been for patients more than 16 weeks pregnant and 116 referrals were for patients who were less than 16 weeks pregnant.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Newly appointed staff underwent an induction process and competency assessment. Scan assistants underwent a probationary period of three months under supervision by a more experienced scan assistant.

We checked all staff files and found that they were complete. All induction training had been completed and the initial assessment for the sonographers had been completed and signed off by the franchisor's lead sonographer. Staff files contained care and service assessments which were completed by peers.

Good

Diagnostic and screening services

The sonographers had received competency-based training as part of their substantive NHS roles and each sonographer maintained their individual competencies as part of their continuing professional development (CPD) certification. Sonographers who did not have a substantive role within the NHS, had undertaken training at the head office of the Window to the Womb franchise.

Sonographers and staff had access to new learning and development videos every three months as part of their continuing professional development (CPD) certification.

All details of training were held within personnel files. All of the sonographers were members of the Society of Radiographers and were registered with the Health and Care Professions Council (HCPC) and we saw evidence of this in the staff files and training documentation. Staff records showed the provider conducted recruitment checks including checks with relevant professional bodies to make sure staff were up to date with their registration.

Appraisal rates for all staff was 100% at the time of our inspection. Managers supported scan assistants to develop through yearly, constructive appraisals of their work. Staff had objectives and targets and had the opportunity to discuss training needs with their manager and were supported to develop their skills. We saw that the clinic manager had recently been put forward for basic life support training.

Multidisciplinary working

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

Staff worked together as a team to benefit patients. We observed good working relationships between scan assistants and sonographers and observed staff supporting each other to provide good care. All staff were part of a group conversation thread on a social media application where they could share information and updates with the team. Team meeting minutes showed good attendance of the full multidisciplinary team with discussions on how to improve care for patients. The registered manager also attended meetings led by the franchisor which was attended by managers of the other franchise clinics where learning was shared.

Staff reported that they had good relationships with the lead sonographer and lead midwife from the franchisor and received timely support when a second opinion or advice was required.

The clinic had good relationships and established referral pathways with local NHS services where patients were referred to if there was an unexpected finding. Sonographers ensured that patients received timely care when referred by ensuring that scan reports were sent immediately to the receiving service. Any urgent matters would be escalated by the sonographer by telephone to the relevant NHS service.

The registered manager had access to a ‘partners page’ on a private social media page where managers of clinics in the franchise could share information and learning.

The service had links with a miscarriage support service and could signpost patients to the service.

Seven-day services

Services were available to support timely patient care.

The clinic was open on Mondays, Wednesdays, Thursdays, Fridays, Saturdays and Sundays.

Patients could book daytime and evening appointments to fit around their needs.

Good

Diagnostic and screening services

Staff could call for support at all times from colleagues including a lead sonographer and a midwife who worked for the franchise.

Health promotion

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

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care. They followed national guidance to gain patients' consent.

Staff were able to articulate to us how to access the Mental Capacity Act policy and the processes outlined within if they had occasion to. Staff received and kept up to date with training in the Mental Capacity Act.

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

We saw that consent was recorded within patient records. We observed a sonographer confirming the patient's identity by asking their name and date of birth and checked that they had consented to the scan before they proceeded.

The service saw young people from the age of 16 years old. They required 16 and 17 year olds to be accompanied by a parent or guardian and requested identification. Staff we spoke with understood Gillick competence and the service had a policy in place.

Are Diagnostic and screening services caring?

Outstanding ☆

We rated caring as outstanding.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. There was a strong, person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive.

Staff were discreet and responsive when caring for patients. We saw staff took the time to interact with patients and their families in a respectful and considerate way. Patients we spoke to and feedback we reviewed consistently reported that staff treated them with kindness and compassion.

We observed staff in all areas of the clinic to be caring and compassionate in their interactions with patients and their families and introducing themselves. Patients commented that staff remembered them from when they used the service for a previous pregnancy and that this made the experience more reassuring and special to be able to be supported by the same staff.

Staff we spoke with understood and respected the individual needs of each patient and showed understanding and non-judgmental attitude when caring for them. They considered patients' emotional and social needs as being as important as their physical needs. Staff told us they were particularly aware of patients' mental health needs and anxieties that had been heightened by the pandemic and told us that they ensured that additional time and support were given to these patients.

We saw staff ensured privacy curtains were used in the scanning room and followed policy to keep patient care and treatment confidential. Scan result discussions were held in the scanning room where conversations could not be overheard, and time was given to the patient and their family to ask questions and go through relevant leaflets with staff.

We viewed comments from patient feedback which were overwhelmingly positive. Comments included: "The whole team were so helpful (on the phone and once I was there"; "staff really put you at ease"; "I would recommend this clinic to everyone. Warm, friendly, inviting, caring, thoughtful and kind and considerate"; "excellent experience from reception staff and sonographer"; "even when we had bad news they are so respectful to your needs and will do anything to make you feel comfortable"; "staff very friendly and welcoming; "staff were so welcoming to me and my partner." One comment from a service user highlighted how staff had been made aware of their situation where their twins were not expected to survive and had opened the clinic on a day they were closed so that scan pictures and heartbeats of the babies could be recorded for the parents to keep.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff gave us examples of how they would support patients who had a history of miscarriage and were anxious. Staff would be briefed at the beginning of their shift so they could offer extra support to patients coming in if needed. A scan assistant was always in the scanning room as a chaperone to the patient.

Sonographers and scan assistants undertook training on having sensitive conversations and breaking bad news. Staff had had training in having difficult conversations as part of communication training which included dealing with loss and bereavement. The service had links with a miscarriage charity which they could signpost patients and their families to.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients who used the service and those close to them were active partners in their care. Patients were made aware at the point of booking that sonographers at the clinic were male and were signposted to another clinic in the franchise if a female sonographer was preferred. The service made a point of explaining the full process of referral into the NHS to patients, so they knew exactly what to expect and to allay any fears or anxieties they had about the appointment. Staff would make a wellbeing telephone call to the patients after they had received unexpected news. Staff told us that this would be made either the next day or a week later depending on the situation and that they would approach the calls with sensitivity.

Good

Diagnostic and screening services

Staff were fully committed to working in partnership with people and making this a reality for each person. They understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff told us that during the pandemic when only one partner was allowed to accompany patients for their scan, they made special arrangements to allow for a patient's terminally ill parent to also come into the clinic in addition the patient's partners so that they could be part of the moment of finding out the gender of their grandchild.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We saw scan assistants and sonographers talking to patients and their families in a way they could understand.

Staff empowered patients who used the service to have a voice in their care and needs. Patients we spoke with told us they were fully involved in their care and were given enough information at the point of booking and on the day of scan about what to bring and how to prepare for their appointment. They told us they felt able to ask questions to the sonographers.

At the time of our inspection, patients could bring up to three people into the scanning room including their children if they had another parent or guardian with them to supervise them at all times. We observed a family who had brought their young child and wanted them to be a part of finding out the gender of the unborn baby. We observed staff arranging for this to happen in the clinic and supporting the patient to share the news with her child.

Patients and families we spoke with told us they were able to ask questions about their scan and staff were friendly and approachable. We observed the sonographer fully explaining what was happening throughout the scan and using appropriate language to explain the position of the baby.

Ultrasound scan prices were clearly displayed on the service's website and the service had laminated sheets at the reception desk so patients could be reminded of what packages were offered. Patients we spoke with told us that prices were made clear to them at the point of booking.

Patients and their families could give feedback on the service online and on comments cards about their treatment and staff supported them to do this.

Feedback received online and on social media about the service was overwhelmingly positive. Many service users commented on the friendliness and professionalism of the staff. The registered manager monitored all feedback received and responded to comments.

Staff supported patients to make informed decisions about their care. Sonographers supported patients to make decisions about the next stages of their care. This included referrals to NHS services when scan results indicated abnormalities. Staff spent extra time ensuring patients understood how the referral process worked and ensured patients were referred to hospitals that were local to them.

Are Diagnostic and screening services responsive?

Good

Diagnostic and screening services

Good

We rated responsive as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

The service offered a range of ultrasound scan procedures for private fee paying adults and for young people aged 16 and 17 years old.

Managers planned and organised services so they met the changing needs of the local population. Clinic opening times allowed people to book appointments to suit their schedules for example in the evening and on weekends.

Appointments were booked in advance, online or by telephone, and this allowed staff to plan the scan procedures before patients attended their appointment.

Facilities and premises were appropriate for the services being delivered. The service had a suitable environment for providing scan procedures to patients. There was enough capacity in the waiting area to allow for social distancing and there was a separate waiting area for patients and families to wait for the printouts of the scans and their scan reports which were emailed to them. A drinks fridge and water dispenser were available in the waiting room for patients and their families to use.

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

There was a quiet room for patients and families to have a private space if they received unexpected news. However, there was no door or screening at the entrance of the room which did not provide patients and families with privacy.

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. They directed patients to other services where necessary.

The service carried out early pregnancy scans from six to 15 weeks and six days and later pregnancy scans from sixteen weeks onwards.

The service had separate clinic sessions split into the morning and the afternoon for patients receiving early pregnancy scans. This ensured that patients who were there for reassurance scans, for example those who had suffered previous miscarriages, did not have to share the waiting room or see patients who were much later on in their pregnancy.

Good

Diagnostic and screening services

There was always a chaperone in the scanning room with the patient. At the time of our inspection the service only had male sonographers and this was made clear to patients at the point of booking and on the website. The registered manager told us they were in the process of looking to recruit a female sonographer to give patients the opportunity to choose if they preferred a female sonographer. They told us that in the interim, if patients had a preference for a female sonographer, they would direct them to another Window to the Womb clinic.

Information leaflets on different conditions were available in the scanning room and were available in English. If a patient did not speak English as their first language, this was recorded at the point of booking so the team could arrange for an interpreter prior to the appointment. The service had a service level agreement with a company that could provider interpreting and translation services.

The registered manager told us they could make arrangements for an interpreter ahead of an appointment if a patient used British Sign Language. They told us there was an occasion where a patient let the team know that they could lipread so the service made additional arrangements to ensure that the scan assistant supported the patient during her scan and made sure the patient could see them clearly as they relayed everything the sonographer was saying in the room at the time.

The service was on the ground floor of a building and was accessible for wheelchair uses and those with limited mobility.

Patients were given information in an email about how to prepare for an appointment and what to bring, including their NHS maternity notes. Reception staff told us they were able to answer queries on the telephone. If a query was clinical, they would escalate this to the sonographer. Patients had access to a mobile application built by midwives, nurses and sonographers where they could access online pregnancy support 24 hours a day, seven days a week and have their pregnancy queries answered by clinical professionals.

Patients had access to a mobile application where they could access their scan images in addition to the printouts from the clinic.

The service also offered a range of baby keepsake souvenir options such as soft toys with the recorded heartbeat of the baby or additional image printouts.

Access and flow

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

The registered manager monitored waiting times and worked with staff to make sure patients did not stay longer than they needed to.

Appointments took up to 12 minutes with a five-minute scanning time and this included time for the patient to ask the sonographer any questions. Staff told us that they did not rush patients who had extra questions and we saw staff taking the time to discuss information with patients. If a referral into the NHS was required, the appointment would take longer and the service ensured that there was enough time factored in between appointments to avoid delaying the next booked appointment. Printouts and scan reports were produced immediately after the scan. Patients had a dedicated area to wait for their printouts and scan reports away from the main waiting area. This allowed for better flow through the clinic and maintaining of social distancing.

Good

Diagnostic and screening services

The registered manager reviewed the flow of patients regularly and had adjusted appointment slots to ensure social distancing protocols could be maintained.

Appointment slots were booked online so slots could not be overbooked but the service had the flexibility to plan in extra slots at the end of each morning and afternoon session if needed. Patients could book early pregnancy scans promptly and were also able to book ahead for later scans of 16 weeks' gestation and above. Slots could be booked on the day and for the next day as well as later dates depending on the patients' preference.

The registered manager told us appointments ran on time and they would ensure that staff had adequate breaks in between sessions to allow for cleaning and staff to have a break. The registered manager told us they rarely experienced patients who did not attend (DNA) their appointment and reflected 2% of appointments. In these cases, they told us they would call the patient and rearrange another appointment time.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients and their families knew how to make a complaint or raise concerns. The service clearly displayed information in the clinic areas on how to make a complaint. We also viewed the complaints policy and saw that it was up to date. Staff we spoke with understood the complaints policy and understood the process of handling complaints. They told us that if there was a complaint or a concern raised, they would try to resolve the issue and if this was not possible, it would be fully investigated by the registered manager.

All complaints, concerns or negative feedback was investigated by the registered manager and we saw that each concern including informal complaints, had been logged in the complaints log and investigated by the registered manager. We saw that a response was given to each individual who had raised a concern.

The service had received 11 informal non-medical complaints and one formal medical complaint in the last 12 months. Reviews on social media platforms were also responded to by the service. We reviewed all complaints and saw that they were responded to in line with the provider's complaints policy.

Complaints were investigated, learning was identified, and the clinic apologised to patients when something went wrong. Informal complaints were generally about scan image quality. In response to these complaints, the service offered the complainant a re-scan.

We reviewed the investigation of the formal complaint which was comprehensive and had been completed by the registered manager and reviewed by the franchisor's lead sonographer and clinical governance panel. Actions following the investigation were in place and managers shared feedback from complaints with staff at the monthly team meetings and learning was used to improve the service.

The registered manager told us that they would receive learning from complaints received at the other franchises and would share these at the monthly team meetings to help improve daily practice.

Are Diagnostic and screening services well-led?

Good

Diagnostic and screening services

Good

We rated well led as good.

Leadership

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

The senior management team consisted of the registered manager and clinic manager. The registered manager was the franchise owner and operator and held overall responsibility for regulatory compliance, with support from the franchisor directors. Day to day leadership was provided by the clinic manager. The registered manager was on-site two days a week and was always available remotely. Support was also provided to the team by the franchisor's clinical lead sonographer and lead midwife who could be contacted at any time for advice. The national franchisor team provided oversight of policies and compliance with national guidance and best practice.

Staff told us that they were supported to develop professionally and were encouraged to develop their skills and access development opportunities. The clinic manager who had recently taken on the role told us that they had received development support to take on the role of clinic manager and continued to be offered opportunities to build on their skills. Leaders told us that they intended to develop all of their staff so that they could take on senior roles within the service.

All staff commented on the friendliness and visibility of the senior management team in the clinic and that they felt able to approach them.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a strategic business plan which explained the mission, vision and values of the service.

The mission of the service was to "provide patient-centred healthcare with excellence in quality, service, and access". Their vision was to "to be an innovative organisation delivering compassionate and safe patient care through a well led and motivated workforce."

The service was aware of the potential of being able to reach more patients in the area if there was more capacity in the service. The strategy set out plans to expand the clinic in the next two years in order to reach more patients in the local area.

They also had plans to serve a wider group of patients and provide gynaecological services for service users post-pregnancy and those going through menopause.

Good

Diagnostic and screening services

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff were passionate about their work and spoke of good teamwork in a patient-centred environment. We found an inclusive and constructive working culture within the clinic among both clinical and non-clinical staff.

We found an open and honest culture and staff told us they felt supported by their managers.

Leaders promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. The registered manager was actively involved in the day to day management of services.

Staff we spoke with were proud of working at the service and spoke highly of the culture, referring to there being a family atmosphere within the clinic.

The registered manager told us all the sonographers and scan assistants worked well as a team and staff told us that they enjoyed working in the service.

Staff we spoke with told us they felt able to report concerns to their managers. There was freedom to raise a concern policy that staff could access if they wished to raise a concern. The director of the franchisor was a freedom to speak up guardian. Freedom to speak up guardians support employees to speak up when they feel that they are unable to do so by other routes. They ensure that people who speak up are thanked, that the issues they raise are responded to, and make sure that the person speaking up receives feedback on the actions taken.

There was a culture of promoting diversity and equality. Equality and diversity was a part of mandatory training.

There were opportunities for staff development. The sonographers were supported to attend training run by the franchisor as well as external organisations such as the British Medical Ultrasound Society (BMUS). The clinic manager had started with the service as a scan assistant and been promoted.

Governance

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

Governance structures were in place at the service. Staff we spoke with had a good awareness of governance arrangements and knew how to escalate their concerns. There were a number of meetings where staff could voice their concerns. The service had clear governance processes in place and the registered manager understood their role about managing governance and ensuring good compliance. The service had a clear governance policy which outlined the responsibility of board members, the relationship between franchisor and franchisee and the requirement for regular audits.

The registered manager had overall responsibility for clinical governance and quality monitoring and reporting this to the franchisor.

There was a policies and procedures folder available for staff to access at the service. These were also available electronically.

Governance systems ensured that recruitment practices were robust. The service followed its recruitment policy and procedures. The service had employed a compliance manager who supported the service by managing training, compliance with policies, supporting the registered manager with customer complaints, undertaking staff appraisals, maintain personnel files and recruitment.

We reviewed all staff records at the service and found that each staff member had references, application forms were filled in in full, employment history was obtained in full, disclosure and barring service (DBS) checks had been completed with updated certificate numbers, proof of identification and interview notes. Sonographers were registered with the Society of Radiographers. Personnel files were audited bimonthly by the registered manager.

The Window to the Womb franchise had medical liability and indemnity insurance which covered all staff who worked for the organisation.

Team meetings were held monthly and were minuted. Minutes were detailed and showed discussion around complaints, updates on guidelines, patient feedback, infection control, training updates and incidents across the franchise.

There were quarterly clinical governance meetings with the franchisor and other managers from the franchise. Minutes showed that discussions were around infection control, risks around ectopic pregnancies, incidents, and information about new services.

There was an audit programme in place which included bimonthly local audits, annual audits and peer review audits. Annual compliance audits by the franchisor included premises checks, health and safety, emergency planning, accuracy and completion of scan reports, completion of pre-scan questionnaires, professional registration and staff records.

The registered manager conducted monthly audits which covered a check on staff documentation, registration and training. This audit also covered checks on policies, maintenance of equipment and emergency plans. Compliance was consistently at 100%.

The service also carried out smaller audits such as cleaning audits and hand hygiene audits and spot checks.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had arrangements for identifying, recording and managing risks, issues and mitigating actions. There was a local risk assessment system (risk register) which included a process of escalation to escalate risks. It was reviewed and updated yearly and new risks added regularly, these covered hazards and precautions in relation to a range of factors, including infection control, and disability access. The risk register included impact and probability levels, and mitigating actions and was reviewed regularly by the registered manager. Updates to the risks or new risks added were shared with the team at the monthly team meetings.

Good

Diagnostic and screening services

There was a corporate risk register that covered all clinics in the franchise. This was maintained by staff at the franchisor's head office. There were six risks on the corporate risk register, including sonographer availability, scan machine failure or fault, ambulance failing to arrive for an emergency, customer self-discharges following a diagnosis of ectopic pregnancy, shortages of PPE for staff, customers refusing to wear face masks. There were mitigations in place including allocated staff responsible for actions and mitigations.

The service had appropriate emergency action plans in place in event of incidents such as power loss or fire. These outlined clear actions staff were to take and contact details of relevant individuals or services. The service did not have a back up generator but if there was a power outage, the registered manager told us that appointments were cancelled and rebooked.

Information Management

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. Data or notifications were consistently submitted to external organisations as required.

Staff received training for information governance and the General Data Protection Regulations. Computer terminals were password protected, and the scanning machine was also password protected.

There were effective arrangements to ensure the confidentiality of patient identifiable data. Computer stations we saw were logged out when not in use. The electronic booking system and customer database were maintained on a secure, cloud based server.

The service was registered with the Information Commissioner's Office (ICO), the UK's independent authority set up to uphold information rights.

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

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

Wellbeing and scan reports in all formats were kept for 21 years, in line with best practice guidance. Paper copies of referrals were kept in a locked cabinet in a room accessible only to staff.

Scan images were stored on the scanning machine for one month on the clinic system after which they were transferred onto a secure drive.

Engagement

Leaders and staff actively and openly engaged with patients and staff. They collaborated with partner organisations to help improve services for patients.

Good

Diagnostic and screening services

Patients were encouraged to share their views on the quality of the service through feedback online. There was a QR code in the waiting area of the clinic so that patients could scan the code with their phones while waiting for their scan reports and printouts to give instant feedback. Patients could give feedback in a number of different ways including comment cards and on social media pages. Feedback was discussed at monthly team meetings and we saw this recorded in the meeting minutes that we reviewed.

Staff were engaged in the planning and delivery of the service. Staff told us that they felt able to suggest new ideas to their managers and that they were listened to.

Staff told us that although during the pandemic, social events had been limited, the service did arrange Christmas parties and celebrated the birthdays of all staff in the service.

Staff also had access to an employee assistance programme which was a free, confidential helpline which staff could access 24 hours a day, seven days a week for advice related to work or any other issues.

The service was in the process of collaborating with an NHS hospital to provide 4D scans free of charge to patients who had had their unborn baby diagnosed with a cleft palate (this is where structures that form the upper lip or palate do not join together when a baby is developing in the womb). The aim of the 4D scan would allow for parents to see the 'whole baby' and help with easing some of the distress that may be experienced after a diagnosis.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

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

The provider made use of technology to gain instant feedback from patients and families using QR codes and social media to help the service continuously improve in real time. The service also sought suggestions from staff at all levels in team meetings to improve the customer experience.

Patients were also offered the option to download a mobile application which allowed them to log in and instantly access to scan pictures that could be easily shared with friends and family. The application used AI (artificial intelligence) technology so patients could track their pregnancy. The service also provided patients with access to an online pregnancy support service for any pregnancy related queries.