Cherish-UK Ultrasound Scans Limited

Cherish-UK

Inspection report

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Requires Improvement**

Summary of findings

Overall summary

We had not previously inspected this service. We rated it as requires improvement because:

- Managers did not identify, mitigate or control all risks within the service.
- The service had out of date equipment and no robust process around the management of equipment.
- The service did not record, monitor or learn from incidents.
- Staff had not had appraisals.
- The service did not have clear and detailed policies.
- Staff did not always robustly complete audits and there was limited action and learning from the results.
- Managers did not check the suitability of all staff that worked in the clinic.
- Managers did not always ensure that there was an up to date Disclosure and Barring Services (DBS) check for all members of staff.
- Medicines were not always stored safely or appropriately.
- Staff did not always ensure that infection control was well managed, and checklists did not reflect the cleaning that took place within the clinic.
- Processes were not clear around how to manage and evacuate a seriously ill adult from the first floor.
- Consent forms did not detail the risks and benefits of the scans provided.
- Managers did not always make sure that complaints were shared and lessons were learned.
- Managers did not always have oversight of the issues within the service including lack of audits, risk assessments, out of date equipment and lack of employment checks.

However:

- Staff treated women 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 women, families and carers.
- The service planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to give feedback. People could access the service when they needed it.

Summary of findings

Our judgements about each of the main services

Service		Rating	Summary of each main service
Diagnostic imaging	Requires Improvement		

Summary of findings

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Summary of this inspection

Background to Cherish-UK

Cherish-UK is a private pregnancy and fertility clinic located in Sutton Coldfield. They provide all types of pregnancy and fertility scanning including, early pregnancy scans, viability scans, baby dating scans, baby gender scans / sexing scans, fertility scans, follicle tracking scans and gynaecological scans. They also provide same-day blood results service for some blood tests.

The service registered with CQC in March 2015. The service has had the same registered manager in post since registration. This is the service's first inspection since their registration with CQC.

How we carried out this inspection

We carried out this announced inspection using our comprehensive inspection methodology on 1 February and 16 February 2023. During the inspection visit, the inspection team:

- Spoke with the registered manager, a consultant nurse sonographer and a clinical and clerical assistant.
- Spoke with 4 women and their families.
- Looked at 5 sets of notes.
- Looked at a range of policies, procedures, audit reports and other documents relating to the running of the service.

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

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.

Action the service MUST take to improve:

Core/additional service [amend as appropriate – if there is only one service, delete this heading]

- The service must ensure that there is an up to date Disclosure and Barring Services (DBS) checks for all members of staff (Regulation 17).
- The service must ensure that cleanliness is maintained and audited within the clinic (Regulation 12).
- The service must ensure that there is an up to date risk register where risks are identified, mitigated and monitored within the clinic (Regulation 12).
- The service must record, monitor and learn from incidents that happen within the clinic (Regulation 12).
- Managers must ensure that appraisals are completed annually for all staff (Regulation 17).
- The service must review all policies to ensure that they are clear and contain all information required (Regulation 17).
- The service must complete detailed audits and create actions plans to continuously monitor the compliance and risks within the clinic (Regulation 17).

Action the service SHOULD take to improve:

Summary of this inspection

- The service should ensure that medicines are stored safely and appropriately (Regulation 12).
- The service should ensure that there is a robust process for stock management and remove all out of date stock from the clinic (Regulation 12).
- The service should ensure that there is a robust recruitment process for all candidates employed by the service (Regulation 12).
- The service should ensure that consent forms detail the risks and benefits of the scans as per their consent policy (Regulation 13).
- The service should ensure that lessons are learned from complaints and these are shared with the staff (Regulation 17).

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Diagnostic imaging

Safe	Requires Improvement
Effective	Requires Improvement
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Is the service safe?

Requires Improvement

We rated safe as requires improvement.

Mandatory training

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

Staff received and kept up to date with their mandatory training. Staff were notified by the registered manager when they needed to refresh mandatory training and told us they were given time to do training. They completed their training on an annual basis every January.

At the time of our inspection, 3 out of 5 members of staff had completed 100% of their mandatory training; there was an overall compliance of 87%. Following the inspection, all staff had completed their training and the compliance was 100%. The mandatory training was comprehensive and met the needs of women and staff. Mandatory training included fire safety, infection control, safeguarding and health and safety.

There was 1 medical staff member, who was not employed by the service, but who worked within the clinic ad hoc once a month to complete smear tests. Managers did not ask for assurances that they had completed their mandatory training.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. The service had safeguarding processes and procedures in place. The consultant nurse sonographers were trained to safeguarding level 4 for both vulnerable adults and children. All other staff members were trained to safeguarding level 2 for vulnerable adults and children and were up to date with their training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with were able to tell us signs of different types of abuse, and the types of concerns they would report or escalate to the safeguarding lead.

Staff knew how to identify adults at risk of, or suffering, significant harm. Staff told us that children did not visit the service due to the size of it and the layout of the building; all patients were told they could not bring children to their appointments. The service did not scan any patients under the age of 18. They asked all patients for their date of birth on attendance.

The service had an up to date safeguarding policy; it did not highlight who the safeguarding lead was for the service. However, as it was a small service, staff were all aware of who it was. Staff stated that it changed on a weekly basis depending on which director was working but both directors were trained to level 4. The policy did not contain information about female genital mutilation (FGM). Staff were able to point us to the Department of Health (DoH) multi-agency statutory guidance on female genital mutilation (2020) that they used if required. Following the inspection, the service updated the policy to include the up-to-date guidance about FGM. The safeguarding training did not include FGM and staff had not received up to date training on this. The consultant nurse sonographers told us that they had previously had training on FGM within a sonography training course and were aware of and able to access the national guidance on it.

The service had a chaperone policy in place. Chaperone signage was displayed in the waiting room indicating that a chaperone was available for women upon request. Staff had not had specific chaperone training.

Cleanliness, infection control and hygiene

The service did not always keep the premises clean. We found dust in some areas and cleaning audits were not robustly completed. However, staff used equipment and control measures to protect women, themselves and others from infection.

Clinical areas were mostly clean and had suitable furnishings which were well-maintained. Cleaning records were up-to-date and completed daily. However, they did not demonstrate detail around the areas that were cleaned. For example, the daily cleaning checklist stated that the scan room was clean and tidy, but it did not say which areas had been cleaned that day. We found that there was surface level dust on the windowsill and fireplace in the waiting room, but the cleaning checklist completed that day said that it was clean. The service had a cleaner who attended once a week and were happy with the standard of cleaning provided. We re-inspected the service on the 16 February 2023 and found that the dust was still in the waiting room. We checked the cleaning checklist and the cleaner had stated that these areas had been cleaned that day. We raised this with the manager at the time of inspection. The staff completed an infection control audit on a monthly basis which was 100% for the last 3 months. We saw that the audit completed on 3 February 2023 stated that the windowsills were clean and dust free; there was dust found in these areas on the 1 and 16 February 2023. Therefore, we were not assured about the validity of the audits.

There was a body fluid clean up kit was used for any bodily fluid spillages.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw that aprons and gloves were worn appropriately and there was adequate stock. Hand sanitiser was available, and visitors were encouraged to use this on entry to the building. The sonography room had a handwashing sink and we saw staff wash their hands between contact with patients. Staff dried their hands on a towel which was washed at the end of each day;

this was not best practice. The service completed a biannual hand hygiene audit which was 100% for December 2022. There was a handwashing policy, but the scope did not match the content within the policy. For example, the scope stated that the policy covered hand hygiene procedures, types of products and when they should be used and skin care for the individual's hands; the policy did not contain this information.

Staff cleaned equipment after patient contact and labelled it to show when it was last cleaned. We saw that the consultant nurse sonographer cleaned the ultrasound probe after each use in line with policy. They recorded the time and date that the probe was cleaned.

Environment and equipment

The facilities were suitable to meet the needs of the patients. However, the design and maintenance of the premises and equipment did not always keep people safe. Risks associated with the design of the building were not always mitigated and essential fire checks were not carried out.

The service had suitable facilities to meet the needs of women and their families. The service consisted of a waiting area, an ultrasound room, treatment room, kitchen and bathroom and a staff area. The waiting area had oversight from the reception desk meaning women and visitors were not left unattended.

The service was set over 3 floors in an old building; the flooring was uneven, there were small steps in reception and the stairs were very steep and narrow. There was signage on the stairs to highlight the steep steps but there was no signage to highlight the risks of the uneven floor within the reception area. The laminate flooring within the ground floor clinic room had a few bumps in it; there was no risk assessment which highlighted these risks and the mitigations taken to reduce the risk. The service completed a quarterly health and safety audit which looked at the floor surfaces. We looked at the previous 3 audits for 2022 and 2023 and they stated the floors were in good repair and there was no increased risk of tripping or falling. Following the inspection, the manager sent a risk assessment of the building which stated they needed to install non-slip tape. The risk assessment lacked detail of where this was to be installed, ownership of the risk, date required for completion and mitigations. We saw on the 16 February 2023 that the non-slip hazard tape had been installed to the small steps within the reception area and the risks were clearly highlighted.

Staff carried out safety checks of specialist equipment. The consultant nurse sonographer conducted daily visual checks which were completed each day the scanner was in use. All equipment was within service date. The ultrasound machine was covered by a service contract supplied by an external contractor and they also provided training for the sonographers. We saw that annual checks had been completed.

The service had enough suitable equipment to help them to safely care for women. However, we found lots of out of date equipment. For example, the first aid kit expired in 2018, a speculum expired in 2021 and we found further items that expired in 2022. We saw that on the risk register it stated that a weekly check of stock was completed; these issues were raised with the manager at the time of inspection and the out of date stock was disposed of immediately. Following our inspection, we saw that the service had a new in date first aid kit.

Clinical and domestic waste was separated and disposed of appropriately. The service had an external contract for the management of clinical waste.

The service had an annual fire risk assessment and fire extinguisher service completed by an external company; this had not been completed since 2021. The service completed a health and safety audit, but it did not look at the fire equipment and safety in detail and therefore did not highlight the out of date servicing and risk assessment as an action needed. This was raised with the manager at the time of inspection. Following the inspection, the service had booked a fire risk assessment to be completed on 20 February 2023.

The service took blood samples when required. These were taken within a clinic room. Sharps were disposed of correctly and sharps bins were all labelled. The service had a service level agreement with a local laboratory who could provide results the same day if required. There was an online system for tracking the samples and obtaining the blood results. We were told that this service was reliable and mostly they got their results on the same day.

We found 3 flammable items which were not stored in a metal flammable cabinet as per Control of Substances Hazardous to Health (COSHH) regulations 2002. We raised this with the manager at the time of inspection. We saw on our follow up inspection on the 16 February 2023 that the service had a metal flammable cabinet where they kept all their flammable items, including oxygen. The managers had limited knowledge about COSHH and did not have any COSHH data sheets or risk assessments for hazardous substances used within the clinic.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and removed or minimised risks. Staff knew what to do and acted quickly when there was an emergency. However, there was no guidance for the use of emergency medications.

Staff responded promptly to any sudden deterioration in a patient's health. The service had a clinical guidelines policy which outlined actions taken in the event of a patient emergency such as ectopic pregnancy. Due to the nature of the service, they did not have an emergency resuscitation trolley. They had a blood pressure machine and pulse oximeter. They had emergency medicines, such as an adrenaline pre-filled syringe, fluids and oxygen on site which were all in date. They stated that these would be used in an emergency only. The fluids were not locked away; this was raised with the manager at the time of inspection and they were immediately locked away. The managers told us that the adrenaline would be used by the consultant nurse sonographers only in an emergency; there were limited guidelines for the use of adrenaline within the clinic, and they were trained in basic life support and were nurse prescribers. However, following our inspection we have seen detailed guidelines in place for the use of adrenaline in an emergency.

A first aid kit was easily accessible. However, supplies were not in date since 2018 and were not checked regularly. Following our inspection, a new first aid kit had been ordered. Staff told us that in a medical emergency they would call 999. The sonography room was located on the first floor which was accessed by steep stairs and narrow corridors.

Staff shared key information to keep women safe when handing over their care to others. There were clear processes in place to refer women with any identifiable anomalies or concerns to the local NHS trusts early pregnancy assessment unit (EPAU), maternity service or to their GP if it was a gynaecology scan. The sonographers completed a report where they shared information noted during scanning leading to the referral for the woman to take to their local EPAU or GP. Staff we spoke with were clear on the referral process to the NHS. There was no formal follow up for women who were referred to the NHS following a concern identified during their scan. Staff told us that they asked the women to let them know their outcomes, however this often did not happen.

Documentation included all necessary key information to keep women safe. Informed consent was taken for both gynaecology and pregnancy scans. Informed consent documentation emphasised the fact that pregnancy scans were elective and non-diagnostic. Wellbeing check scans included gestational age of the baby and various biometric

measurements. Documentation clearly stated that measurements taken during scanning did not replace those made at NHS appointments and highlighted the importance of attending their scheduled NHS appointments which were provided for diagnostic purposes. We noted that the consultant nurse sonographer did not routinely provide verbal confirmation of this information to women and families when attending for a scan.

The staff were able to see the number of times a patient attended for a pregnancy scan. They advised patients were scanned a maximum of every 2 weeks up to 30 weeks of gestation; they would not scan more frequently than this. Re-scanning rates were not monitored by the service.

Consultant nurse sonographers checked the patient identify before scanning. They used three points of identification checking the woman's name, date of birth and address.

The service followed ALARA (As Low As Reasonably Achievable) principle, which meant that equipment was set to the lowest possible settings, and a maximum amount of time set for exposure to ultrasound of 20 minutes.

The service completed blood tests on patients, usually after a risk had been shown within the NHS. They did not offer an antenatal service but were able to support women with next steps depending on the results of their blood tests. They had a service level agreement with a laboratorywho processed their blood results. If abnormal results were detected, the staff would contact the patient to ask for their GP details. They would then speak to the GP on the patient's behalf for a follow up and forward the results to the patient and GP.

An accident book was used to record accidents and injuries, we saw 2 accidents had been logged since 2017.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care. However, the service were not able to provide assurances around the consultant's practice.

The service had enough staff to keep women safe. The service employed 2 consultant nurse sonographers, 1 sonographer and 2 clerical and clinical assistants. One sonographer and one clerical and clinical assistant worked at any one time. The service had recently employed a third sonographer to support the increasing demand for the service to offer Saturday appointments and ad hoc Thursday afternoon clinics. The managers, who were both consultant nurse sonographers, worked a week on and a week off and rotated between each other. This ensured that there was always a manager on site. The registered manager worked in the service. Clerical and clinical assistants were responsible for managing enquiries and appointment bookings; consultant nurse sonographers and the sonographer completed the ultrasound scan procedures, gave the women advice where required and printed scan images.

The service had low vacancy, turnover, and sickness rates and staff described the team as consistent and stable. They did not use any bank staff.

The service worked with a gynaecology consultant who completed smear tests for patients alongside a chaperone. These were booked in on an ad hoc basis when an enquiry was made through the website or via the phone. These patients were then booked in based on the availability of the consultant. We were told these occurred on average once a month. The consultant also practiced within the NHS. The service did not ask for a Disclosure and Barring Service

(DBS) check, training records, appraisal data or any assurances regarding the consultant's practice. This meant that the service could not be assured that the consultant was up to date and safe with their practice. Following our inspection, they had asked the consultant for an up to date appraisal and mandatory training records. We were assured that the DBS would be requested following inspection.

Records

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

Patient notes were detailed, and all staff could access them easily. Records were stored securely. Women's scanning records were stored securely on the computer and scanning images were stored on the ultrasound machine backup. Consent forms were completed and then immediately uploaded onto the patient's online record; the paper consent form was subsequently shredded.

Data regarding the women was obtained prior to their scan. For example, allergies, number of weeks pregnant and any significant medical history.

We looked at 5 sets of medical notes. We found that all contained relevant medical history and consent was completed.

Medicines

The service stocked emergency medicines only. However, we found some out of date patients own medication in an unlocked draw and emergency fluids were not locked away.

The service did not stock or administer medicines for any scanning procedures. These were not required for the type of service offered.

The service stocked a pre-filled adrenaline syringe, oxygen and one bag of fluids which could be used within an emergency. These were all in date; the fluids were not locked away as per best practice. We raised this with the manager at the time of inspection.

We found out of date medication stored within an unlocked drawer in the kitchen adjacent to the downstairs scanning room. We raised this with the manager at the time of inspection. They told us that these were donated to them by a fertility patient to use on another patient if required; they had not been administered. The manager disposed of these medications whilst we were still on site.

Both nurse consultants were prescribers. Within the clinic, they mostly prescribed progesterone up to 16 weeks in pregnancy where women had experienced a previous miscarriage. We saw information that was given to the women who were prescribed progesterone and the service followed up to date national guidelines regarding recurrent miscarriage. They had a policy which detailed when to give the progesterone.

Incidents

The service managed safety incidents informally. Staff did not report incidents and near misses. Managers did not investigate incidents or share lessons learned with the whole team. However, when things went wrong, staff apologised and gave women honest information and suitable support.

Staff knew what incidents were, but they did not report them. The service did not have an incident reporting policy. The manager told us that they saw complaints as incidents and shared learning from these verbally with the team. We were

told that there had been no safety incidents within the last 12 months that would require reporting. We found that no incidents had been recorded since the clinic had been opened. Therefore, we were not fully assured that staff did report incidents. However, as it was such a small team, we were told that staff discussed incidents informally within the clinic if they happened. Following our inspection, the manager sent a newly written incident reporting policy. However, it was unclear in some sections and the content did not match the description; it also lacked detail around which incidents should be reported. This could be confusing for staff if they required guidance. Near misses were not reported or included within the incident reporting policy. Following the inspection, the service had introduced an incident book where incidents were now recorded.

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

The service had no never events.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. 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. The staff 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. The incident reporting policy did not detail what the duty of candour was and what the requirements were for the clinic to adhere to it.

Staff discussed feedback informally and we were told this was done daily as it was a small team. We were told that feedback was discussed in team meetings and they looked at improvements to patient care. We saw team meeting minutes for staff from December, October and July 2022 and there were no minutes documenting that discussion of incidents that had happened within the clinic or any improvements needed to patient care. However, it was evident that this was done informally, and staff were able to talk about incidents that had happened within the clinic and how these were managed. However, 2 staff members were not always within the clinic due to part time hours. Managers did not share the meeting minutes with staff who could not attend. This meant that these staff did not always know what had been discussed within the meetings.

Is the service effective?

Requires Improvement

We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and procedures based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff knew how to access policies. Policies were stored both electronically on an internal computer drive and paper based. Local policies and procedures were in line with current legislation and national evidence-based guidance from professional organisations, such as the National Institute for Health and Care Excellence and the British Medical Ultrasound Society (BMUS).

Staff were made aware of updates to policies via email or verbally. Policies we checked were up to date and within review date. The registered manager had an electronic record of all policies with their review date which ensured policies were reviewed by the service in a timely manner.

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 BMUS, Guidelines for Professional Ultrasound Practice (December 2018)). This meant consultant nurse sonographers used minimum frequency levels for a minimum amount of time to achieve the best result.

Patient outcomes

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

Outcomes for women were positive, consistent and met expectations, such as national standards.

Consultant nurse sonographers took part in a peer review process to ensure the accuracy and quality of ultrasound scan images, videos, and reports. These were done informally between the 2 consultant nurse sonographers. These were discussed and used for improvement.

The registered manager ensured there was a clear criteria for undertaking scans and repeating scans. This was to ensure women were not persuaded to have multiple scans, which would not have given them any more information than they already had.

The service kept a record of women referred to NHS antenatal care providers. However, they did not routinely follow up these referrals to monitor outcomes or review anomaly detection rates.

Competent staff

The service made sure staff were competent for their roles. Managers did not appraise staff's work performance and or hold 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 women. The service was run by two nurse consultants who were experienced nurses and were qualified in pregnancy and gynaecology scanning. They were both registered with The Society and College of Radiographers. They had recently employed a sonographer who did pregnancy scanning only. They had completed shadow shifts with the consultant nurse sonographers prior to completing their own clinic. The managers checked the sonographers reports and scans to ensure they were of good quality.

Managers gave all new staff an induction tailored to their role before they started work. We spoke to a clerical and clinical assistant who had shadowed her colleague until they were competent within their role. We saw competencies were completed.

Managers recorded interviews for the appointed candidates but did not obtain references for their staff on recruitment into the role. They had worked within the NHS with the staff that they had employed and were confident about their abilities to complete the job. We did not see a recruitment policy or a risk assessment which mitigated the need for obtaining references. Following our inspection, we were told that there were forms to obtain references when the service felt that they were required.

Managers had not supported staff to develop through yearly, constructive appraisals of their work. One staff member was not due an appraisal, but of the other 2 members of staff, 1 had not had theirs since 2019 and the other had not had one since starting in 2020. This meant that they had not been provided the formalised opportunity to discuss performance and opportunities for development. We saw that in October 2022 team meeting the team discussed the need for appraisals and it was decided that they would be completed in 2023. Following the inspection, all staff were given paperwork to complete and a date for their appraisals. We observed a team meeting on 16 February 2023 and the managers had found some online courses relevant to the service such as endometriosis for staff to undertake which would be funded by the service. The consultant nurse sonographers did not appraise each other as they did not feel that this was needed.

Multidisciplinary working

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

The team worked well together and communicated effectively for the benefit of the women and their families. This included the registered manager, consultant nurse sonographer, sonographer and clinical and clerical assistants.

Staff worked across health care disciplines and with other agencies when required to care for women. The service had links with the local NHS trusts to ensure they had effective referral pathways for women when needed. Staff had established good working relationships with the local trust and were able to telephone the service to secure an appointment for women before they left the clinic if required. For women whose maternity care was with another trust, a written referral was given to the woman to take to their local trust; the manager also said that they would phone the hospital to make them aware of the patient if required.

We observed positive staff working relationships which promoted a relaxed environment and helped put women and their families at ease.

Seven-day services

Services were available to support timely patient care.

The service was open Monday to Friday 8am to 1:30pm and responded to emails until 17pm. The service offered the occasional afternoon and weekend appointments to enable women to book scans at a time that suited them. They had recently brought on a new member of staff who was going to work 3 or 4 Saturdays per month. Women could book appointments online, email or by telephone. Appointments were often available the next working day.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. There was information on baby safe first aid, folic acid in pregnancy, baby massage and hypnobirthing in the reception area.

The sonographers referred women to miscarriage charities when they were experiencing a miscarriage.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported women to make informed decisions about their care. They followed national guidance to gain women's consent. However, risks and benefits were not detailed on the consent forms as per their policy.

Staff understood how and when to assess whether a patient had capacity to make decisions about their care.

Staff gained consent from women for their care and treatment in line with legislation and guidance. The service had consent forms for scans which detailed what happened within the scan. The consent form for pregnancy scans clearly stated that it did not replace the routine scans provided by the NHS and that they did not provide antenatal care. However, it did not detail risks of frequent scanning or any other associated risks of scanning. There was no consent policy at the time of inspection; the service sent a newly written policy following our inspection. This stated that the consent process should include the associated risks and benefits; this was not detailed on the consent forms.

Staff made sure women consented to treatment based on all the information available. Staff clearly recorded consent in the women's records. We reviewed 5 consent forms and found that these were completed in full. Patients we spoke to told us that the felt well informed about the decisions and next steps by the staff.

Is the service caring?

Good

We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. Women told us that the service was efficient and professional.

Women said staff treated them well and with kindness. Staff were very helpful and reassuring. They answered questions patiently and interacted with women and their families in a friendly and sensitive manner. If a scan was not able to obtain satisfactory images due to positioning of the baby, they were able to attend another scan at no extra cost.

Women and their companions were able to leave feedback via social media platforms, which the registered manager frequently monitored. We found the service was very highly rated and feedback was overwhelmingly positive. We saw over 70 positive testimonials from patients who had had treatment at the service. There was also 241, 5-star search engine reviews with no negative reviews achieved since they had opened.

Staff followed policy to keep patient care and treatment confidential. Staff ensured scans were conducted in a way that protected the women’s privacy and dignity. Staff kept the door to the scanning room locked during the scan to ensure women’s privacy was maintained and women were covered throughout. A privacy screen was used for women who needed to remove clothing.

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs.

Emotional support

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

Requires Improvement

Diagnostic imaging

Staff gave women and those close to them help, emotional support and advice when they needed it. We observed 4 scans and found the staff to be very understanding and supportive to women during their scans. One woman told us that they had previously had a number of pregnancy losses and felt reassured by the staff and they explained everything really well and were very supportive.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. Women could exit through an alternative route without having to pass through reception area after receiving bad news. This meant that they could leave discreetly if they wished without seeing other women and their families.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. We saw feedback on social media sites that gave examples of how supportive the staff had been. For example, one wrote "despite the difficult situation with a sad outcome, Cherish-UK were so supportive, and you could tell they were genuinely upset for us. We will always be thankful for this."

Staff understood the need to be compassionate and sensitive when a scan indicated cause for concern. Staff told us that they explained the referral process and the need for further diagnostic tests.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of women and those close to them

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

Staff made sure women and those close to them understood their care and procedures. We saw staff explained care in a way that they could understand and allowed them plenty of time to ask questions.

Staff talked with women, families and carers in a way they could understand, using communication aids where necessary.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. Feedback was given through social media and search engine review sites.

Women gave positive feedback about the service. We reviewed feedback which was all positive. For example, one review said "An amazing clinic with an infinitely kind, friendly team of professionals. It was a pleasure to visit the clinic and I will do it again in the future". Another said, "I have used this clinic on multiple occasions and have always received an excellent professional service with outstanding care. You are more than a number which I have felt elsewhere, and the staff genuinely care".

Staff supported women to make informed decisions about their care. Staff made sure women were told about the different scans available and the costs associated with them. Staff provided women with various leaflets signposting them to other care providers.

Is the service responsive?

Requires Improvement

Diagnostic imaging

Good

We rated it 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.

Managers mostly planned and organised services so they met the needs of the local population. Women could pick the time slot that suited them and could book appointments at short notice. The registered manager told us that each slot was either half an hour or an hour long so that there were no delays and they could spend the time with each woman. The service was open 8am until 1:30pm from Monday to Friday. The service had recently employed another sonographer who was going to do Thursday afternoons and most Saturdays to give more availability for scanning.

Facilities and premises were appropriate for the services being delivered. There was enough seating in the waiting area. The scan room was large with enough seating and additional standing room for women, their partners, family and friends who attended the scan with them. There was a scanning room downstairs if patients had limited mobility as the main scanning room was located on the first floor.

Managers ensured that women who did not attend appointments were contacted and rebooked if required.

Meeting people’s individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They directed women to other services where necessary.

The service provided pregnancy ultrasound scans and gynaecology 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 friends and family, were given a sealed envelope with a note telling them whether they were expecting a boy or a girl.

Managers made sure staff, and women, loved ones and carers could get help from interpreters or signers when needed. Although the service did not have access to interpreters or signers, staff had access to an online translation service. We were told that one woman brought her own translator with her to the appointment.

The service offered women a heartbeat bear which could be purchased. Heartbeat bears contained a recording of the unborn baby’s heartbeat.

Access and flow

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

Requires Improvement

Diagnostic imaging

All women self-referred to the service. The service recognised women often preferred to use the internet, or mobile phone application so offered different booking methods. Women could book their scan appointments in person, by phone, or through the service's website.

Reasonable adjustments were made to ensure people with a physical disability could easily access and use the service. The premises had accessibility for wheelchairs, although there was one small step to enter the reception area. There was a scanning room downstairs which could be used to support women with limited mobility. The main scanning room was on the first floor of the building.

Staff supported women when they were referred or transferred between services; women were not routinely contacted following a referral to NHS services. The service logged all patients who required further scanning within the NHS and asked the women to inform them of their outcomes, but this often did not happen.

Learning from complaints and concerns

People were able to give feedback and raise concerns about care received but information about how to make a complaint was not readily available. The service treated concerns and complaints seriously and investigated them, but we did not see evidence of shared lessons learned with staff.

Women, relatives and carers knew how to complain or raise concerns. However, the service did not display information about how to raise a concern in patient areas. Information on how to complain was available on the service website but it was not easy to find. Complaints could be made verbally and by email.

The service had received 3 complaints in the 12 months prior to our inspection. We saw that the complaints had been investigated and responded to. For example, a patient was not happy with the results of their scan and how it had been handled and the service apologised, and they offered a full refund.

The service welcomed online reviews through social media and search engine rating sites. The service took steps to respond to feedback. The manager told us that they had not received any negative feedback on social media sites since opening.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints but we did not see evidence that feedback was shared from complaints with staff and learning was used to improve the service. However, due to it being such a small team, we were told that informal discussions were had and learning was shared verbally.

Staff knew how to acknowledge complaints and understood the complaints policy. Staff knew how to resolve minor concerns and avoid minor issues escalating into a formal complaint.

Is the service well-led?

Requires Improvement

We rated it as requires improvement.

Requires Improvement

Diagnostic imaging

Leadership

Leaders had some of the skills and abilities to run the service. But they did not always understand and manage the priorities and issues the service faced. They were visible and approachable in the service for women and staff.

The service was very small with 5 members of staff. It had a clear leadership structure in place. The registered manager was also a company director. The service was run by 2 directors who were nurse consultants. They told us they managed the service together and spoke daily. They worked one week on and one week off each; the manager who was on that week was the point of contact for staff and patients. They performed most of the scanning within the clinic; they had recently employed a sonographer who worked on an ad hoc basis.

The manager was aware of the service's performance, limitations and the challenges it faced. There was a business continuity plan in place which detailed potential issues that could arise. There were mitigating actions and the issues identified were RAG rated. However, they did not always follow their own plans. For example, the business continuity plan stated that they wanted to hold scenario planning training with staff to ensure guidance in place; the manager told us that this had not been completed but was highlighted within 2022 that it needed to be completed.

Staff told us that the managers were friendly and approachable. Staff felt confident to discuss any concerns they had with them and were able to approach the manager directly, should the need arise.

Regular communication took place between the registered manager and staff. Due to the small number of staff in post, staff saw each other on a regular basis to discuss issues affecting the service. They were also participants in a social media application group that facilitated secure real-time communication; staff told us they used this for a lot of their communications.

In the event of the registered manager being off site, staff could contact them by telephone.

Vision and Strategy

The service had a vision and values in place which defined how they wanted the service to be delivered.

Staff were passionate about providing a positive and happy scanning experience at the service. The vision was to continue to provide a 'high quality service for patients on their journey through pregnancy and for women undergoing assessment of their gynaecological health'.

The service's values were 'committed to excellence, patient focussed, compassionate and respectful, ethical, diverse and inclusive, transparent and passionate'.

The managers told us that the values focused on creating a positive experience for women whilst treating all with fairness and respect.

The service had a strategy which focussed on delivering quality evidence-based care in an open and transparent environment.

Culture

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

Staff we met were friendly, welcoming and confident. Staff told us they felt supported, respected, and valued. They enjoyed coming to work and were proud to work for the service. Staff told us that it was an open and inclusive culture and they felt able to raise concerns with their managers.

Managers looked after their staff's wellbeing and staff felt managers were supportive to their needs.

Governance

Leaders did not operate an effective governance process. There was a lack of oversight of issues, risk management, learning, appraisals and auditing within the clinic. The policies, audits and risk assessments lacked detail.

The service had a process to version control policies and procedures. Records showed policies were regularly reviewed and updated. The manager said any changes or updates to policies were shared by email. Staff told us that due to it being a small team, they verbally discussed changes. The policies lacked detail and clarity and the service did not always follow their own policies. For example, the consent policy had a different title and within the policy it stated that risks and benefits would be discussed. However, the consent forms did not detail any risks of the scans being performed. Therefore, we were not assured that patients were made aware of all risks associated with scanning.

The staff completed audits however, they did not produce any associated action plans and they did not always hold value. For example, the health and safety audits were completed, but they did not prompt checking of fire equipment. This meant that these were not regularly checked, and staff were not aware that the fire extinguishers were out of date for service in 2021. There was a lack of oversight of issues surrounding risk, health and safety, clinic management and infection control these were not picked up through regular audits. For example, trip hazard risks within the building were not minimised or risk assessed, out of date equipment was found throughout the building, areas were unclean when checklists stated they had been cleaned and actions were not addressed promptly.

Staff told us the team was small and updates were shared daily with staff as required. The registered manager held a regular staff meeting but learning from incidents and complaints, audit results and patient feedback was not discussed. However, we were told that because it was such a small team, everything was discussed with the staff verbally. We saw that the lack of appraisals was discussed in October 2022 and one staff raised that they would like some further training. However, the appraisals were not booked, and managers said that they would be organised after Christmas 2022. These were discussed again at January 2023 meeting and it was decided that they would be organised following one of the directors leave in February 2023. Following the inspection, two staff members completed appraisal paperwork and their appraisals had been schedules.

The service held a monthly team meeting. We saw minutes for January 2023 which discussed staff hours, new tests that the service would like to provide, and equipment needed. We also attended a team meeting on 16 February 2023. The staff did not discuss incidents, complaints, audits or policies. We were told these were discussed verbally when they happened. When staff did not attend, they were not provided with minutes of the meeting. The managers also had a board meeting where performance, audits and governance were not discussed; we were not assured that lessons were learned and actions were taken to improve compliance through the governance process.

There were 2 out of 5 members of staff and one consultant who were out of date for their Disclosure and Barring Services (DBS) checks; this is a check of the staff's criminal records. There was no policy which stated how often they

should be completed but best practice was that it should be done every 3 years. Some of the staff's DBS had not been checked since 2015 and the consultant had not had a check with the service. We raised this with the managers at the time of inspection and they had relied on that it had been completed within the NHS but had not asked to see a copy of it.

The service employed a consultant on an ad hoc basis to perform smear tests; this took place on average, once a month. The service had not completed any employment checks, for this consultant and had not asked for any assurances around their practice including NHS appraisals or training. This meant that managers could not be assured that they were safe and did not have full oversight of their practice.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not identify and mitigate relevant risks or identified actions to reduce their impact.

The service did not have robust systems in place to manage risk. They did not effectively use audits to make improvements or complete risk assessments to monitor the quality and safety of the service. Where risk assessments had been completed, there was no risk owner, date of completion and they lacked detail and mitigations.

Health and safety audits were completed but risk assessments such as fire and health and safety had not been completed and there were no action plans associated with the audits. There was a fire risk evacuation procedure, but fire extinguisher checks and the annual fire risk assessment were out of date. All staff completed had mandatory fire safety training.

The service had a basic risk register and all staff were aware of these risks. Whilst the register highlighted risks, there were no owners of the risks, dates added and completed, scoring of the risk and the mitigating actions were brief and did not include all actions needed to mitigate the risks. The service had highlighted 3 risks; staff absence due to sickness which would cause disruption to the clinic, scan machine failure and inability to acquire stock from suppliers. We found that mitigating actions were not detailed and did not include all actions they took. For example, the mitigating action for scan machine failure was to ensure the spare scan machine was available for use. However, it did not detail that they checked the machine daily and serviced it annually. We also found risks that were not on the risk register or risk assessed such as the trip hazards within the building. The service sent an updated risk register following the inspection, but it still lacked detail and mitigations required to reduce the risks within the clinic. The service had an accident book and an accident had been recorded in 2017 where someone tripped over the step in the reception area. Nothing had been actioned to reduce this risk since 2017. Following the inspection, the service put hazard tape on the steps to highlight them. However, we were still not assured that there was full oversight of the risks within the clinic.

The service had policies and procedures for patient referral into the NHS, although some of them lacked detail and information was confusing and lacked clarity. For example, in the incident reporting policy there was a section which detailed 'what incidents should be reported' and subsequent bullet points. These bullet points were 'guidance for staff and managers on incident management, reporting requirements and processes and duty of candour requirements. This therefore, gave no guidance around what incidents should be reported within the clinic.

We were told that there were regular peer review of image quality and areas of improvement to benefit women. However, there was no documented evidence of these occurring.

Diagnostic imaging

Staff were clear about their roles, but appraisals did not take place to discuss performance and development. Managers told us that they had highlighted in their January 2023 board meeting that they needed to complete staff appraisals; we saw this within the meeting minutes and October 2022 meeting minutes as well.

The service had a business continuity plan and valid public and employer liability insurance.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed to make decisions and improvements. The information systems were integrated and secure.

The service had arrangements and policies to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems were in line with data security standards.

Records and scans were electronic, password protected and stored securely. Consent was paper-based and was shredded following the appointment once it was manually uploaded onto the system. The service had an offsite backup resource so in the case of damage or theft, the computer records were recoverable.

The service had a data protection policy and all staff completed training in information governance. Terms and conditions of the treatment women were received were found on the service's website and all patients were given a copy of this.

Engagement

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

Staff had regular engagement with the registered manager through informal discussions and through email. The registered manager was involved in the day-to-day running of the service alongside the other director and when not on site, was easily contactable by phone.

The service encouraged women to provide feedback through online reviews, social media reviews or email. We saw positive examples of feedback and the registered manager had responded appropriately to feedback.

The service had completed a patient satisfaction survey in between February and July 2022. They had received over 80 responses and all the responses were positive with no negative comments to the 10 questions asked. Responses included "We were seen on the day of our phone call and treated brilliantly" and "Staff member was extremely comforting and reassuring, we could not have asked for a nicer experience".

The service's website offered multiple routes for women to contact staff to get information. There was also a frequently asked question section on the website.

Learning, continuous improvement and innovation

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

Requires Improvement

Diagnostic imaging

The directors were both nurse consultants and had master's degrees with qualifications in scanning and prescribing. They were very passionate about their role and felt that this sets them above other clinics who did the same service. The service won a number of awards over the years including community business awards and an award at the Central England Prestige Awards for 'Ultrasound Clinic of the Year' in June 2022 and had just been told they have won it again this year.

The managers said that they were looking at offering a new service which was 98% accurate at diagnosing endometriosis; this had not yet been put into place but the tests had been ordered and it had been discussed in their team meeting in February 2023.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must ensure that there is an up to date Disclosure and Barring Services (DBS) checks for all clinical members of staff (Regulation 17). • Managers must ensure that appraisals are completed annually for all staff (Regulation 17). • The service must review all policies to ensure that they are clear and contain all information required (Regulation 17). • The service must complete detailed audits and create actions plans to continuously monitor the compliance and risks within the clinic (Regulation 17).

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service must ensure that cleanliness is maintained and audited within the clinic (Regulation 12). • The service must ensure that there is an up to date risk register where risks are identified, mitigated and monitored within the clinic (Regulation 12). • The service must record, monitor and learn from incidents that happen within the clinic (Regulation 12).