Hey Baby 4D South East Group Limited

Hey Baby 4D Colchester

Inspection report

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

Ratings

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

Summary of findings

Overall summary

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

- The service had enough staff to care for women and keep them safe. Staff had training in key skills, understood how to protect women from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- 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 women and made sure that women had access to information.
- 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.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women to plan and manage services and all staff were committed to improving services.

However:

- There was no formal follow up for women who were referred to an NHS service following a concern identified during their scan.
- There was no formalised quality assurance programme in place for ultrasound equipment.
- There was no back up arrangement in place for data that is stored within the clinic's computer system.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Good 	

Summary of findings

Contents

Summary of this inspection

Background to Hey Baby 4D Colchester

Hey Baby 4D Colcheter is operated by Hey Baby South East Group Limited. The service provides private pregnancy scanning services and serves the communities of Essex. The service provides ultrasound scans for reassurance or gender determination from 6 to 42 weeks of pregnancy. Appointments include scan findings and images for keepsake purposes. In the event of anomaly detection, women were referred to the local NHS early pregnancy assessment unit or maternity service, depending on the stage of pregnancy.

The service registered with CQC in July 2021. 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 unannounced inspection using our comprehensive inspection methodology on 1 November 2022During the inspection visit, the inspection team:

• Spoke with the registered manager a sonographer and a scanning assistant

• Spoke with six women and their families

• 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 SHOULD take to improve:

- The service should ensure that there is a formalised quality assurance programme in place for ultrasound equipment.
- The service should consider implementing a formal follow up for women who were referred to an NHS service following a concern identified during their scan.
- The service should consider using data and information more robustly for audit purposes to further drive learning and service improvement.
- The service should ensure that there is a back up arrangement in place for data that is stored within the clinic's computer system.
- The service should consider recording patient details when completing ultrasound probe cleaning documentation.

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	Good	Good	Good	Good
Overall	Good	Inspected but not rated	Good	Good	Good	Good

Good

Diagnostic and screening services

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

Are Diagnostic and screening services safe?

Good

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. Staff were notified by the registered manager when they needed to refresh mandatory training and told us they were given time to do training.

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,

The registered manager ensured staff completed mandatory training. At the time of our inspection, 100% of staff had completed and were up to date with 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 clear safeguarding processes and procedures in place. The sonographer and scan assistants were trained to safeguarding level two for both vulnerable adults and children. The registered manager was trained to safeguarding level three.

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 registered manager.

Staff told us that safeguarding training included learning about female genital mutilation (FGM) and provided staff with clear guidance on how to identify and report FGM.

The service had an up to date safeguarding policy. The policy included processes for staff to obtain support in the event a woman under the age of 16 attempted to obtain a scan.The service did not scan women under the age of 18.

Good

Diagnostic and screening services

The service had a chaperone policy in place. Chaperone signage was displayed in the waiting room indicationg that a chaperone was available for women upon request.

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable furnishings which were visibly clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff completed daily, weekly and monthly cleaning checks. We reviewed lists and saw that they were completed as per location policy.

Staff followed infection control principles including the use of personal protective equipment (PPE). Aprons and gloves were available and we saw that staff used them appropriately. Staff wore face masks and asked that service users wore a mask when accessing the service.

Staff cleaned equipment after patient contact using appropriate cleaning products. We saw that the sonographer cleaned the ultra sound probe after each use in line with policy. They recorded the time and date that the probe was cleaned. However this was not recorded against the patient record meaning that it was not possible to see from the records that the probe had been cleaned consistently.

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.

Staff carried out daily safety checks of specialist equipment. The sonographer conducted daily visual checks which were completed each day the scanner was in use. However there was not a regular quality assurance (QA) programme in place. The medicines and healthcare products regulatory authority states that there should be a regular programme of equipment QA testing.

The equipment was within service date. The ultrasound machine was covered by a service contract supplied by an external contractor. We saw that annual service checks had been completed.

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

The service had enough suitable equipment to help them to safely care for women.

Staff disposed of clinical waste safely. Clinical and domestic waste was separated and disposed of appropriately.

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.

Good

Diagnostic and screening services

Staff responded promptly to any sudden deterioration in a patient's health. The service has an emergency and significant events policy which outlines actions to take in the event of a patient emergency. Due to the nature of the service they did not have an emergency resuscitation trolley. A first aid kit was easily accessible. Supplies were in date and well organised. An accident book was used to record accidents and injuries. Staff told us that in a medical emergency they would call 999.

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) or maternity service. The service used a referral form where they shared information noted during scanning leading to the referral for the woman to take to their local EPAU. Staff we spoke with were clear on the referral process to NHS services. However, there was no formal follow up for women who were referred to an NHS service following a concern identified during their scan.

Documentation included all necessary key information to keep women safe. Informed consent documentation emphasised the fact that 4D scans were elective and non-diagnostic. Wellbeing check scans included gestational age of the baby and various biomemtric measurements. Documentation clearly stated that measurements taken during scanning did not replace those made at NHS appointments and the importance of attending their scheduled NHS appointments which were provided for diagnostic purposes. We noted that the sonographer did not routinely provide verbal confirmation of this information to women and families when attending for a scan.

Sonographers checked the patient identity before scanning. They used three points of identification checking the womans name, date of birth and address.

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

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.

The service had enough staff to keep women safe. The registered manager planned staffing levels to meet demand on the service, measured by the number of bookings made in advance. The service employed one sonographer and three scan assistants. The registered manager worked in the service. Scan assistants were responsible for managing enquiries, appointment bookings, supporting the sonographers during ultrasound scan procedures and printing scan images.

The service had low vacancy, turnover, and sickness rates and staff described the team as consistent and stable.

Locum sonographers were used in the service to cover holidays and sickness as required. The registered manager told us that they used regular locum staff who were familiar with the service. All locum staff had a full induction. There was also access to other sonographers from another location of the service provider .

Records

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

Patient notes were comprehensive and all staff could access them easily.

Good

Diagnostic and screening services

When women transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Womens scanning records were stored securely on the computer and scanning images were stored on the ultrasound machine backup. Consent forms were stored on site in a secure, locked cabinet.

Medicines

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

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The service had an up-to-date incident reporting policy, which detailed all staff responsibilities to report, manage and monitor incidents. The service used a paper-based reporting system, and an incident log was available in the clinic. The registered manager was responsible for conducting investigations, took actions and shared learning with staff.

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

Staff understood the duty of candour. In the same period, there were no duty of candour notifications. 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 registered manager could explain the process they would undertake if they needed to implement the duty of candour because of an incident, which was in line with the requirements.

Staff met to discuss feedback and look at improvements to patient care. Feedback was given informally on a daily basis. Staff had access to feedback and updates during monthly staff meetings.

Are Diagnostic and screening services effective?

Inspected but not rated

Evidence-based care and treatment

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

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 protocols were in line with current legislation and national evidence-based guidance from professional organisations, such as the National Institute for Health and Care Excellence (NICE) and the British Medical Ultrasound Society (BMUS).

Good

Diagnostic and screening services

Policies were written centrally by the franchise. However, policies were adapted to provide effective guidelines for each clinic location. Staff were made aware of updates to policies at monthly team meetings. 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 British Medical Ultrasound Society (BMUS), Guidelines for Professional Ultrasound Practice (December 2018)). This meant 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. The service had been accredited under relevant clinical accreditation schemes.

Sonographers took part in a peer review process to ensure the accuracy and quality of ultrasound scan images, videos, and reports. Review included scan times, gender or health inaccuracies. These were shared and discussed and used for improvement between the two provider locations.

The registered manager ensured there were 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 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 women. The sonographer employed by the service as a qualified radiographer, registered with the Health and Care Professional Council (HCPC).

Managers gave all new staff a full induction tailored to their role before they started work. Each scanning session was run by a sonographer and scanning assistant. New sonographers worked alongside an experienced sonographer until they were competent with scanning procedures and equipment.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff completed an appraisal which provided the opportunity to discuss performance and opportunities for development. The appraisal rate for the service was 100%.

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, sonographer and scan assistants.

Good

Diagnostic and screening services

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 the woman before she left the clinic. For women who's maternity care was with another trust a written referral was given to the womant to take to her local trust.

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 Tuesday 12 to 8pm, Thursday 11am to 7pm and Saturday and Sunday 9am to 5pm.

The service offered evening and weekend appointments to enable women to book scans at a time that suited them. Women could book appointments online or by telephone. Appointments were usually 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 healthy diets, baby massage and hypnobirthing in the reception area.

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.

Staff understood how and when to assess whether a patient had the 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 benefits and risks. Consent forms for scans outlined the limitations of the scans relating to anomaly diagnosis, maternal health and gender of the foetus.

Staff made sure women consented to treatment based on all the information available. Women were sent the consent form in advance of attending their appointment.

Staff clearly recorded consent in the women's records. We reviewed consent forms and found that these were completed in full.

Good

Diagnostic and screening services

Are Diagnostic and screening services caring?

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 staff provided women with drinks, suggest they go for a walk or attend another scan at no extra cost.

Women and their companions were also able to leave feedback on open social media platforms, which the registered manager frequently monitored. We found the service was very highly rated and feedback was overwhelmingly positive.

Staff followed policy to keep women's care and treatment confidential. Staff ensured scans were conducted in a way that protected 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.

Staff gave women and those close to them help, emotional support and advice when they needed it. We observed staff being very understanding and supportive to a woman who had come to the clinic very anxious having had a scan earlier in the week and being confused by what she had been told. Both the sonographer and the scanning assistant were patient and caring and took time to expain, answer questions and offer reassurance.

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 the reception area after receiving bad news. This meant that they could leave discreetly if they wished without seeing other women and their families.

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.

Good

Diagnostic and screening services

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 treatement.

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

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 “excellent service, clear communication, respectful of our requests. Overall fantastic experience. Another said “fantastic service. Very professional, very caring.”

Staff supported patients 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 and reminded women they should attend their NHS appointments.

Are Diagnostic and screening services responsive?

Good

Service delivery to meet the needs of local people

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

The registered manager planned and organised services so they met the changing needs of the local population. Women could pick the time slot that suited them. The registered manager told us that they did not book all available slots so that they had capacity if appointments overran or if someone needed an appointment at short notice.

Facilities and premises were appropriate for the service being delivered. There was sufficient 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. Children of all ages were welcome to attend.

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 only provided private pregnancy ultrasound scans. They did not undertake any ultrasound imaging on behalf of the NHS or other private providers.

Women who wanted to find out the gender of their baby outside of their appointment, such as at a gender reveal party with their family and friends, were given a sealed envelope with a note telling them whether they were expecting a boy or a girl.

Good

Diagnostic and screening services

The service offered women a range of baby keepsake and souvenir options which could be purchased. This included heartbeat bears, a selection of photo frames, fridge magnets and gender reveal products such as scratch cards and shooting cannons. Heartbeat bears contained a recording of the unborn baby's heartbeat.

Although the service did not have access to interpreters or signers staff had access to an online translation service.

Access and flow

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

All women self-referred to the service. The service recognised women often preferred to use the internet, or a 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 were located on the ground floor of the building with easy access for wheelchairs. The scanning room contained an adjustable couch which staff used to support women with limited mobility.

Staff supported women when they were referred or transferred between services. However women were not routinely contacted following a referral to NHS services.

Learning from complaints and concerns

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

Women, relatives and carers knew how to complain or raise concerns. Information on how to complain was available in the reception area and on the service website. Complaints could be made verbally and by email.

The service had received two complaints in the 12 months before our inspection. We saw that the complaints had been investigated and responded to. One complaint concerned image quality and the complainant was invited in for a second scan. The other complaint related to a woman feeling uncomfortable getting changed in the ultrasound room. The service responded by obtaining a dignity screen for the room.

The service welcomed online reviews through social media and search engine rating sites. The service took steps to respond to feedback, both positive and negative, to establish ways they could improve. The registered manager told us that in the 12 months prior to our inspection there had been no negative reviews on social media platforms.

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.

Good

Diagnostic and screening services

Are Diagnostic and screening services well-led?

Good

Leadership

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

The service had a clear leadership structure in place.The registered manager was also the company director.

Sonographers and sonography assistants reported directly to the registered manager.

The manager demonstrated an awareness of the service's performance, limitations and the challenges it faced. They were also aware of the actions needed to address those challenges.

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

The registered manager maintained a visibility within the service, engaging regularly with staff. The registered manager worked regularly at the location and when on site would work covering reception.

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.

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

Vision and Strategy

The service had values in place defining how they wanted the service to be delivered.

Staff were passionate about providing a positive and happy scanning experience at the service. The service's values were 'fun, family, fair and friendly'.

The values focused on creating a positive experience for women whilst treating all with fairness and respect.

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 were aware of the whistleblowing policy.

The registered manager explained how the ethos of management was to identify improvements and encourage everyone to work as a team to overcome challenges.

Good

Diagnostic and screening services

Governance

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

The service had a process to version control policies and procedures. Records showed policies were regularly reviewed and updated. The registered manager said any changes or updates to policies were shared by email and discussed with staff at daily briefing and during team meetings.

The registered manager monitored audits, training and appraisals. They told us the team was small and updates were shared daily with staff as required. The registered manager held a monthly staff meeting where updates were shared, learning from incidents and complaints, patient feedback and training opportunities.

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.

The service had systems in place to manage risk, such as audits and risk assessments to monitor the quality and safety of the service.

Risk assessments such as fire and health and safety had been completed and the action plans implemented. There was a fire risk evacuation procedure, fire extinguishers and smoke detectors. All staff completed mandatory fire safety training.

The service had updated their general and COVID-19 risk assessments that identified actions which had been completed to mitigate risks. These risk assessments were reviewed regularly as guidance changed. At the time of our inspection staff wore face masks and service users were asked to waer a mask when accessing the service.

The service had policies and procedures for patient referral. There were regular peer review audits of image quality and areas of improvement to benefit women.

Staff were clear about their roles and had appraisals to discuss performance and development.

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

Information Management

The service collected 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.

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. However, the service computer did not have an offsite backup resource so in the case of damage or theft of the computer records were not recoverable. We highlighted this at the time of the inspection and the registered manager said that they woukld review this.

Good

Diagnostic and screening services

The service had a data protection policy and all staff completed training in information governance.

Safeguarding notifications were submitted to external organisations in line with local policy when required

Engagement

Leaders and staff actively and openly engaged with women, staff, and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women.

Staff had regular engagement with the registered manager through informal meetings and through email. The registered manager was involved in the day-to-day running of the service 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 shared examples of how feedback had been used to plan and manage services. For example, putting a dignity screen in the scanning room following a concern that was raised. 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.

The service proactively used learning from incidents. We saw examples of where learning had been used to ipmprove the service for women and their families. For example, the addition of a dignity screen in the scanning room following a women raising a complaint.