Colchester Clinic

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Colchester Clinic is operated by Diagnostic Healthcare Limited. Colchester Clinic is an independent health provider delivering a range of non-obstetric ultrasound and dual-energy X-ray absorptiometry (DEXA) scans. It is a stand-alone purpose-built diagnostic and screening facility providing scanning services to NHS patients contracted by the local NHS community trust.

We inspected the service using our comprehensive inspection methodology. We carried out an unannounced inspection on 29 January 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

We rated this service as requires improvement overall. We rated it as requires improvement for the safe and well-led domains, and good for the caring and responsive domains. We do not currently rate the effective domain.

We rated the service as requires improvement because:

- Staff were not always familiar with or adhering to best practice and local policy in relation to hand hygiene and infection prevention and control (IPC) processes.
- The spot checks and audits of IPC compliance did not document actions to address issues identified, to reduce the risk of them reoccurring.
- The environment was challenging, as it was not sufficiently spacious in the waiting area to allow for private conversations.
- Staff working in the DEXA room did not know where the local rules for the DEXA room were and were not able to confirm they were aware of what they entailed or whether they had signed a copy of them.
- There was no trefoil (radiation warning) sign at the entrance to the DEXA room to clearly show the words 'x-ray' and 'controlled area', although the service addressed this immediately when we raised it.
- There was no formal patient records audit carried out locally by the service.
- Not all staff were clear on the correct process and policy for reporting incidents.
- We had concerns that the environment did not allow for maximum respect for patient privacy and dignity.
- There was no policy around whether sonographers should 'break bad news' or refer it to the patient's GP to discuss with the patient, which meant there was potential for inconsistencies in how sonographers treated concerning results and difficult conversations.
- On days when the clinical lead was not on site, there was a lack of clear interim site leadership, although the lead would be contactable over the telephone for support. It was generally only once a month that this lead was not on site.
- There was limited evidence of a clear vision and strategy at local level to outline steps for targets to achieve or continuous development, although there was a corporate vision at provider level.

Summary of findings

- Not all risks we identified on our inspection were captured on the risk register and staff could not identify their main risks for the Colchester location specifically.
- The provider wide staff survey was carried out every three years and the last survey was completed in 2015 which meant they were overdue their staff survey and therefore were not receiving regular feedback from staff. There were no additional staff surveys carried out at local service level.

However, we also identified the following areas of good practice:

- The service had achieved a 100% compliance rate with staff completion of mandatory training.
- Staff we spoke with understood their roles and responsibilities in regards to safeguarding.
- The service maintained its environment and equipment well.
- There were clear processes to escalate concerns to patients' GPs.
- Records were clear, up-to-date, accurate and secure; there were systems to ensure GPs had prompt access to scan records.
- The service had systems and processes to ensure staff were competent for their roles including a comprehensive induction programme.
- There was evidence of good multidisciplinary team working.
- Staff displayed a kind and compassionate approach and communicated with patients in a caring way.
- The service planned and provided services in a way that met the needs of local people. The service took account of patients' individual needs.
- The service had a clear exclusion and inclusion criteria and only booked patients in accordance with this to ensure they would be able to meet their needs.
- Staff felt well supported by service leads and each other and there was a positive team-based culture.
- Staff confirmed they received important updates and information from the clinical site lead verbally and through emails.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with two requirement notices that affected Colchester Clinic. Details are at the end of the report.

Amanda Stanford

Deputy Chief Inspector of Hospitals (Central Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Requires improvement 	Diagnostics was the only activity the service provided. We rated this service as requires improvement. The summary of findings can be seen above.

Summary of findings

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Requires improvement

Colchester Clinic

Services we looked at:
Diagnostic imaging

Summary of this inspection

Background to Colchester Clinic

Colchester Clinic is operated by Diagnostic Healthcare Limited. Colchester Clinic is an independent health provider delivering a range of non-obstetric ultrasound and dual-energy X-ray absorptiometry (DEXA) scans. It is a stand-alone purpose-built diagnostic and screening facility providing scanning services to NHS patients contracted by Anglian Community Enterprise.

The scans provided by the service include abdominal, renal, musculoskeletal, pelvic, deep vein thrombosis (DVT), testicular and transvaginal ultrasound scans.

It is one branch of four registered locations in total, all operated by Diagnostic Healthcare Limited, which is registered in Manchester and all the governance functions operate in Manchester at the headquarters.

The service has one full time sonographer and two sonographers on zero-hours contracts, one full time and two part time diagnostic imaging assistants, and one full time receptionist.

The service provides services from 9am to 5pm Monday to Friday. Scans are booked through the local NHS community trust. Sonographers, who are self-employed and contracted by Colchester Clinic, conduct the scans and report back to the patient's GP.

The service, as a location, has not been previously inspected, although there have been inspections of other registered locations operated by Diagnostics Healthcare Limited.

There is a registered manager in place and the service is registered for the regulated activity of diagnostic and screening procedures as of 6 June 2018.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector and a specialist professional advisor. The inspection team was overseen by Martine Pringle, Inspection Manager.

Information about Colchester Clinic

The service is registered to provide the following regulated activities, as of 6 June 2018:

• Diagnostic and screening procedures.

The service at site level employed sonographers, diagnostic imaging assistants, a radiographer and administrative staff.

During the inspection we visited the dual energy x-ray absorptiometry (DEXA; for bone density scanning) room, three ultrasound scanning rooms, the reception and patient waiting area, and the store room. We spoke with six members of staff. We observed two patient pathways and reviewed patient records and other documents.

There were no special reviews or investigations of the service ongoing by the CQC at any time or during the 12 months before this inspection.

Activity

From June 2018 to January 2019, the service performed over 7,000 scans which included over 80 scans on 16-17 year olds and performed no scans on patients under 16.

From June 2018 to January 2019 the service received eight complaints.

Track record on safety (June 2018 – January 2019)

- No deaths in the service
- No reported never events.

Summary of this inspection

- No serious incidents
- No IRMER/IRR reportable incidents
- No duty of candour notifications.
- No incidences of hospital-acquired infections.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as **Requires improvement** because:

- Staff were not always familiar with or adhering to best practice and local policy in relation to hand hygiene and infection prevention and control (IPC) processes.
- The spot checks of IPC compliance did not document actions to address issues identified, to reduce the risk of them reoccurring.
- The environment was challenging, as it was not sufficiently spacious in the waiting area to meet the demands of bookings and the number of patients accessing the service, although the service was running at unusually high demand on the day we visited.
- Staff working in the DEXA room did not know where the local rules for the DEXA room were and were not able to confirm they had signed a copy of them.
- There was no trefoil (radiation warning) sign at the entrance to the DEXA room to clearly show the words 'x-ray' and 'controlled area', which was not in line with the service's own requirements, although the service addressed this immediately when we raised it.
- There was no formal patient records audit carried out locally by the service.
- Not all staff were clear on the correct process and policy for reporting incidents.

Are services effective?

We do not rate diagnostic imaging services for the effective domain.
We found:

- GPs had prompt access to records of scans.
- The service had systems and processes to ensure staff were competent for their roles including comprehensive induction.
- There was evidence of good multidisciplinary team working.
- Staff had good awareness of consent and mental capacity.

Are services caring?

Good

We rated caring as **Good** because:

- Staff cared for patients with compassion. They respected patients' privacy and dignity, and supported their individual needs.

Summary of this inspection

- Staff provided emotional support to patients to minimise their distress, although there was no policy to state clearly whether sonographers should 'break bad news' meaning there was a risk of inconsistency in practice.

Staff involved patients and those close to them in decisions about their care and treatment.

Are services responsive?

Good

We rated responsive as **Good** because:

- The service planned and provided services in a way that met the needs of local people.
- The service took account of patients' individual needs.
- The service had a clear exclusion and inclusion criteria and only booked patients in accordance with this to ensure they would be able to meet their needs.
- People could access the service when they needed it.
- Complaints were managed and investigated in accordance with local policy, although the policy that was in hard copy on site was five months out of date.

Are services well-led?

Requires improvement

We rated well-led as **Requires improvement** because:

- On days when the clinical lead was not on site, there was a lack of clear interim site leadership, although the lead would be contactable over the telephone and this generally only happened once a month.
- There was limited evidence of a clear vision and strategy at local level to outline steps for targets to achieve or continuous development, although there was a general vision at provider level.
- Not all risks identified were captured on the risk register and staff could not identify their main risks for the Colchester location specifically.
- The provider wide staff survey was only carried out every three years and the last survey was completed in 2015 which meant they were overdue their staff survey and were not receiving regular feedback from staff. There were no additional staff surveys carried out at local site level.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Requires improvement	N/A	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	N/A	Good	Good	Requires improvement	Requires improvement

Requires improvement

Diagnostic imaging

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

Are diagnostic imaging services safe?

Requires improvement

We rated safe as **requires improvement.**

Mandatory training

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

- The service had processes to monitor staff compliance with mandatory training. Staff received mandatory training initially as part of their induction and were required to complete all mandatory training each year. Modules included, but were not limited to, health, safety and welfare at work; basic life support; infection prevention and control; fire safety; and information governance.
- Data from December 2018 showed there was 100% compliance with mandatory training attendance and staff confirmed they received sufficient time and support to complete training.
- Sonographers were self-employed and worked within a small and regular core group at the service. They managed their own training and registration and were monitored by provider's HR team to ensure compliance with company requirements such as indemnity insurance and mandatory training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

- The service had not made any safeguarding referrals in the year prior to our inspection.
- Staff had completed training in safeguarding adults and safeguarding children level 2. The service treated patients aged 16 and over. All staff had up to date safeguarding training. The lead for safeguarding within Diagnostic Healthcare was trained to level 3 in safeguarding for both adults and children. The organisation also had a 'Prevent' lead. Prevent is the duty placed on specified authorities to have due regard to the need to prevent people from being drawn into terrorism.
- Staff we spoke with understood their roles and responsibilities in regards to safeguarding vulnerable people. Staff could explain safeguarding arrangements and when they would be required to report issues to protect the safety of vulnerable patients. Staff also told us who they would report safeguarding concerns to, although the staff we spoke with told us they had not had to raise any safeguarding concerns to date.
- The service had an up to date safeguarding vulnerable adults and children policy. The policy contained relevant guidance for staff to recognise and report any potential safeguarding concerns. The policy contained information on number of different types of abuse including child sexual exploitation, female genital mutilation (FGM) and human trafficking. The policy included details on who should be contacted if a member of staff had safeguarding concerns.
- Arrangements for checking all staff were fit to work with vulnerable adults and children were effective and essential checks had been carried out. The service carried out a Disclosure and Barring Service (DBS)

check on all newly appointed staff. DBS is the process by which employers can check the criminal record of employment candidates. All staff working in the service had a current DBS check recorded. The service had an electronic system to check renewal dates of DBS checks. Records of DBS checks were kept at the provider's Manchester headquarters.

Cleanliness, infection control and hygiene

The service had some processes in place for the control of risk of infections, but we had concerns these were not always adhered to or audited.

- All areas we inspected were visibly clean.
- There was inconsistency in staff compliance with best practice in hand hygiene, in accordance with National Institute for Health and Care Excellence QS61 (Infection prevention and control). The radiographer working in the dual-energy x-ray absorptiometry (DEXA) room said they would change gloves between patients and 'sometimes' use disinfectant wipes for hand cleansing between patients. They did not have hand gel in the DEXA room at the time of our inspection. This was not best practice and was not in accordance with the service's IPC policy.
- We raised the issue of the lack of hand gel with service leads at the time of inspection and they provided assurances they would remind all staff verbally and via email that hand washing or hand gel was mandatory between patients. We were assured that their prompt actions were sufficient to address this concern. The staff we observed in the ultrasound rooms washed their hands before and after each patient direct contact or episode of care, and there was a sink and hand gel in each of the ultrasound rooms.
- There was a provider-wide infection prevention control policy which was up to date and outlined waste management and cleaning responsibilities. However, due to the concerns about hand hygiene in the DEXA room outlined above, we were not assured all staff were familiar with it, although when we raised this with the service leads they took steps to immediately address this risk.
- There was an up to date provider-wide policy for the decontamination of transvaginal probes. This stated that probes were to be cleaned immediately after the scan using sterilising wipes activated by water and specified how to clean the probe using this equipment to ensure decontamination. The sonographer would then record this process on the end of day report sheet and the service electronic patient information system. This was in accordance with British Medical Ultrasound Society (BMUS) Safety Guidelines 2009 and the manufacturer's recommendation.
- There was a cleaning schedule in place to ensure regular cleans of different areas were carried out at the appropriate time, for example, daily floor, surface and fixture cleaning and quarterly machine/chemical cleaning of hard floors.
- Daily cleans were carried out by an external company. We reviewed the completed cleaning logs for January 2019 and saw all cleaning responsibilities had been completed and signed off.
- There was also a specific ultrasound equipment cleaning schedule. This was the responsibility of the sonographer and diagnostic imaging assistant in each clinic room. We saw this was carried out and signed off within an end of day report specific to each clinic room and then sent off to the provider's head office.
- The service had reported no healthcare acquired infections in the last 12 months.
- The service carried out monthly audits of IPC and cleanliness, including random spot checks of staff compliance with infection control policy and procedure including hand hygiene, 'bare below the elbows', and cleaning equipment between patients. Each element was documented as a yes or no with a separate box for comments if required.
- We reviewed documentation of these spot checks and audits between October 2018 and January 2019 and saw good compliance, although no percentages were calculated to monitor trends, improvement or decline. Where issues were identified, we were told this would be discussed with the individual member of staff, but there was no documentation to evidence this. For example, one spot check from January 2019 noted that a member of staff was not compliant with policy as they had painted nails, but no actions to address

this were documented. This was a concern because we could not be assured the service was acting on IPC issues and documenting them to reduce the risk of them reoccurring.

Environment and equipment

The premises of the service were challenging to meet the demands and number of patients, although the service had systems in place for the maintenance of the premises and equipment.

- The site was located in a business park and comprised of a waiting area, including a reception desk and toilets, and a separate clinical area with five ultrasound clinic rooms and one dual energy x-ray absorptiometry (DEXA) room. One of the ultrasound clinic rooms was no longer in use as it was where obstetric scans were previously carried out, but the service no longer provided this procedure. There was also a storage room, small staff room with a kitchen and a meeting room.
- The size and layout of the clinic was challenging, as it was not sufficiently spacious in the waiting area to meet the demands of bookings and the number of patients accessing the service. This was not on the risk register for the service. This was acknowledged by a member of staff we spoke with as an issue because the environment was not best suited for having private or difficult conversations. Over the course of the day the waiting room became full, with limited space to hold private conversations or move around, although everyone was seated. Parking space was also very limited.
- When we raised the concerns around the environment and layout with the registered manager following inspection, we were told there were service plans to improve the site layout to improve the patient experience and service delivery. This would involve combining two small consulting rooms, one of which was disused as it had previously been used for the obstetric clinics which were no longer taking place. This would create a more spacious area but there was no date fixed for this work to commence.
- The location was appropriately secure, with buzzer entry and a separate entrance/exit between the waiting area and the clinical corridor where the scanning rooms were located.
- The maintenance and use of equipment kept people safe. We saw equipment was serviced and maintained regularly. Staff were appropriately trained to use equipment and would not use any without their competencies being signed off. We observed staff using equipment appropriately during our inspection.
- We checked a range of serviceable equipment including the defibrillator, scanners, and fire extinguisher and saw they were all within servicing date. There was a service level agreement (SLA) in place for the maintenance and repair of faulty equipment and we saw records of items of equipment that had been serviced and repaired in line with this.
- Consumable items of equipment were stored in a storage room in a cabinet. We checked a range and saw it was all within date.

Assessing and responding to patient risk

We had some concerns about the lack of clear systems in place for assessing and responding to patient risk, particularly within the DEXA room.

- Under the service level agreement with the NHS, the service only provided scans to patients who were low risk. There was a set of exclusion and inclusion criteria for both ultrasound and dual-energy x-ray absorptiometry (DEXA) scans, which included not seeing patients under 16 years old for ultrasound and no patients under 18 years old for DEXA. The criteria excluded cancer referral patients, thyroid scans and non-NHS patients.
- We were told of some incidences where patients were referred mistakenly by their GP and did not meet the criteria and this only became apparent when they arrived at the clinic, for example a bariatric patient who could not be treated by the service. These events were reported as incidents. We were told that in these incidences, the service would explain to the patient that they had been incorrectly referred and would then contact the patient's GP to reiterate the referral criteria and why the patient did not meet it.
- We had concerns because the radiographer who was the sole member of staff working in the DEXA room, did not know where the local rules for the DEXA room were and was not able to confirm they were aware of what they entailed or whether he had signed a copy of

them. Regulation 17 of the Ionising Radiation Regulations (IRR) 1999 states that "Written procedures in the form of Local Rules must be produced for any Controlled Area and, depending on the nature of the work, any Supervised Area" and that the service must ensure the local rules "as are relevant are brought to the attention of those employees and other persons who may be affected by them". The purpose of this requirement is "to assist the RPS in instructing workers in radiation protection and, in the event of an accident, to provide a clear reference to prepared contingency plans".

- When we raised this concern with service managers, they confirmed the local rules were accessible on the provider's human resources (HR) portal, including the signed copy, and that the local rules were covered as part of induction. They addressed the concerns immediately by sharing a reminder with all staff about how to access policies and spoke with the radiographer to ensure they re-familiarised themselves with the local rules and other policies, so we were assured any risk was promptly mitigated.
- The service had a radiation protection supervisor (RPS) who was not based at the Colchester site but was contactable over the phone. However, there was no notice anywhere in the room saying who the RPS was and their telephone number. This meant if a radiation incident occurred with the equipment then the contact information for the RPS was not readily available. The contact information was included in the local rules for the DEXA room but due to our concerns about the local rules, above, we were not assured at the time of inspection that staff would be able to readily access this.
- The service's 'Scatter Dose and Shielding Report/ Operator Dose and Recommendations' specified that there should be 'as a minimum a radiation trefoil sign provided at the door entrance and include the words 'x-ray' and 'controlled area'. We had concerns because there was no trefoil (radiation warning) sign at the entrance, which was not in accordance with the report and recommendations. We raised this with service leads and they provided assurances to address this risk, namely that they ordered a sign to be produced and displayed on the door, and in the meantime a temporary sign was displayed.
- There were clear processes to escalate unexpected or significant findings during procedures and upon reporting. Staff told us how they would refer patients back to their GPs and we saw evidence of this on the patient records system and in the individual records we reviewed. This was done on the same day if the scan showed concerning findings, as per their agreement with the local community trust.
- There was a deteriorating patient policy which provided that if a patient deteriorated suddenly or unexpectedly, the service would dial 999. Staff we spoke with were aware of this.
- There was no resuscitation equipment on site except a defibrillator, due to the nature of the service and the low risk of the patients it was treating.
- All members of staff had basic life support (BLS) training and records showed staff members had completed this. BLS training gives staff a basic overview of how to deal with a patient who may have stopped breathing, such as starting cardiopulmonary resuscitation.
- All patients who had a transvaginal ultrasound scan were asked if they had any allergies to latex. Patients were also asked to sign the form next to this question and to confirm their response. The service had both latex and non-latex covers for the transvaginal ultrasound probe and would select the cover according to the response from the patient.
- The service only accepted patients who were physically well and could transfer themselves to the couch without support.

Staffing

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

- Each clinic room was staffed by a sonographer and diagnostic imaging assistant (DIA). This meant the patient was always escorted to and from the waiting room by the DIA and the DIA could make notes in the patient records as the sonographer was scanning. There was one radiographer employed by the service who carried out the dual energy x-ray absorptiometry (DEXA) procedures.

Requires improvement

Diagnostic imaging

- The service used an electronic rota to ensure the clinics had the appropriate staffing levels and skill mix.
- Data from December 2018 showed there were vacancies in the service for one full time equivalent (FTE) DIA and one FTE receptionist. However, when we asked service leads at the time of our inspection in January 2019 they said they were always looking for more staff but gave no specific vacancy rates for the site. They said there was constant demand so they were in ongoing conversations with the local clinical commissioning group (CCG) regarding recruitment.
- The service did not use bank and agency staff at the time of our inspection. The registered manager told us that if agency staff were booked then they would have to complete the and mandatory training before they could work at the service and would have their competency, checked
- From June 2018 to December 2018, the sickness rate for sonographer staff was 10.6% and for receptionist staff it was 2.3%. For DIAs and radiographer staff there were no incidences of staff sickness.
- From June 2018 to December 2018, there had been no turnover among any of the staff groups in the service.

Records

Staff kept detailed records of patients' care and treatment and transferred them appropriately to patients' GPs.

- The service used an electronic system to record patient notes. During the clinics we observed, the diagnostic imaging assistant completed notes as the sonographer scanned the patient; the sonographer then completed the summary of their findings once the scan had been completed. This meant there was minimal delay between scans and record completion.
- All patients were referred by the NHS service and once the sonographer had completed the scan it would be sent electronically to the patient's GP immediately, with a separate copy stored in the provider's electronic system which was secure and password protected.
- Records were clear, up-to-date and easily available to all staff providing care. Images and scan reports were transferred from the ultrasound machine to a server automatically and they were made available to patient's GP and the referring community trust.
- All records were legible, clear and detailed. We reviewed four sets of patient records during our inspection. All patient records were electronic which contributed to the clarity and consistency of record completion. All appropriate information was recorded within the records we reviewed.
- There was no formal records audit carried out locally by the service which meant there was a risk that any issues with records would not be identified at site level and highlighted to staff, although we were told that an internal provider-wide records audit took place quarterly and an external one yearly.

Medicines

- The service did not use any controlled drugs or medicines.

Incidents

There was a system for managing and learning from patient safety incidents, although we had concerns about the consistency of staff confidence with the process and policy.

- The service reported no never events or serious incidents from June 2018 (their date of registration) to January 2019. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Staff were able to give examples of incidents that had happened in the service and actions taken, such as when patients were referred who did not meet the criteria, but said they had not had to report any themselves recently.
- There was a provider-wide policy for incident reporting and investigation. The process was to complete an online form which was sent to the head office and the registered manager and staff to also

informed the clinical site lead directly. There was a compliance manager based at the Manchester head office who was responsible for reviewing and investigating incidents.

- We had concerns that not all staff were clear about the process for incident reporting. A sonographer and DIA told us there was a book to record incidents, in hand written form, stored in the staff office which was not in line with policy or what managers had told us. Another member of staff was aware of the electronic reporting process. We raised this with service leads immediately after our inspection and they were unsure of why there was discrepancy in the knowledge of incident reporting. They took actions to address this, namely verbal and email reminders to staff about the correct process for incident reporting.
- There was a weekly email in which learning from incidents was shared. There was also a staff meeting for the whole provider twice a year where any learning from incidents across the sites operated by the provider was discussed.
- Regulation 20 (Duty of Candour) of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014 requires healthcare organisations to notify relevant persons (often a patient or close relative) that an incident has occurred, to provide reasonable support to the relevant person in relation to the incident and to offer an apology. No incidents had occurred in the preceding twelve months that met the threshold for the Duty of Candour to be applied. However, staff were able to describe their requirement to be open with patients and there were processes in place for staff to follow. The service did not have a separate Duty of Candour policy however, the requirement to be open was included Diagnostic Healthcare's significant event policy.

Are diagnostic imaging services effective?

We do not currently rate diagnostic imaging services for the 'effective' domain.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

- Most policies and procedures were used across the provider's locations rather than just at the Colchester site to try and ensure consistency between sites. Policies and procedures were based on national guidelines and best practice. For example, the transvaginal ultrasound policy made reference to the Society and College of Radiographers and British Medical Ultrasound Society (BMUS) 2015 joint document 'Guidelines on Professional Ultrasound Practice' and the BMUS Safety Guidelines (November 2009).
- The provider's imaging protocols and report writing guidelines were written by the clinical leads and medical director using national best practice advice, adhering to National Institute for Health and Care Excellence guidelines, Care Quality Commission recommendations, Society of Radiographers and British Medical Ultrasound Society guidelines. Policies were ratified and reviewed annually through the Clinical Governance Committee.
- Staff confirmed that they would be made aware of any significant changes to policies or guidance through emails from the head office.
- There were clear processes for scanning and reporting. Sonographers wrote the report directly into the company electronic patient reporting system and the report was sent to the referrer within 24 hours. Where there were clinically urgent findings, or a second opinion was required, the sonographer alerted the patient service team based at the provider's Manchester head office. We were told the provisional report was sent to the referrer immediately and the patient's GP practice was informed that an urgent report had been sent.
- The service's consultant radiologist provided their opinion on clinically urgent findings within 24 hours which was added as an addendum to the original sonographer's report. Following this review, a final report was sent to the referrer. This process was all recorded on the company patient management system to make sure all urgent and second opinion cases were actioned.

Nutrition and hydration

Diagnostic imaging

The hydration needs of patients and those accompanying them were met.

- There were water jugs in the waiting room for patients and relatives.
- For certain types of scans, such as abdominal scans, patients were required to have a full bladder to enable clearer imaging. Advice to drink at least two pints of liquid prior to the examination was included as part of the information patients received on their clinic letter.

Pain relief

Patients' pain and comfort were discussed and considered.

- Due to the nature of the service provided the service did not give pain relief.
- Staff said that if patients were experiencing pain or discomfort during the scan they would stop. However, during the scan, we observed the sonographer and DIA did not ask the patient whether they were experiencing any discomfort throughout the scan.

Patient outcomes

The effectiveness of care and treatment were monitored and reviewed at provider level, although there was inconsistency in the feedback provided to staff at location level to ensure results were acted on and improved.

- There was a local audit schedule including, but not limited to, monthly key performance indicator (KPI) audits, six monthly machine maintenance audits and spot checks on competencies done by the clinical site lead or through peer review. Results of these were reviewed and monitored at head office and discussed at clinical governance meetings; however, there was limited evidence of systems to ensure key findings from audits were fed back to operational staff at location level.
- There was routine auditing of sonographers' clinical competencies. The clinical site lead checked a sample of the images and reports undertaken by each practitioner. This involved rating the quality of images from A to C and whether they agreed or disagreed with the sonographer's report and rationale where they did not agree or felt something was missing.
- We reviewed the clinical competencies audits completed for July to September 2018 and saw they involved a comprehensive review with comments for improvement or additional consideration. This was then shared with the individual member of staff who was being audited, although there was no evidence of it being shared with the wider team, for example through meetings so that all staff could learn from them. The results were not quantified in percentages to assess whether performance was improving over time.
- At the time of our inspection, Diagnostic Healthcare Limited as a provider was working towards the Imaging Services Accreditation Scheme (ISAS). The first stage of this application was due to be completed later in 2019.

Competent staff

The service had systems and processes to ensure staff were competent for their roles.

- Managers supported staff with appraisals, support and supervision and opportunities to update and further develop their skills.
- Clinical staff had a pre-employment clinical assessment and if there were any major concerns about the scanning, report writing or patient and colleague interaction, this was explained and the role would not be offered.
- Staff completed an induction period where they were mentored by an experienced member of the team. This ensured the sonographer worked within their scope of practice and to the expected standard. The time allocated was dependent on the sonographer and their experience. They received feedback following induction and the induction could be extended if they were not yet confident.
- Following the induction, if staff did not meet the competencies and management did not feel they would meet the standards required then they would not .
- Continuing professional development was mandatory for the sonographers in maintaining skills and competencies and for the radiographer in maintaining professional registration. The provider supported staff to have time off for study days and refresher training

as required by the provider. However, there was limited additional funding and support for staff to complete external additional training or competency development. One member of staff we spoke with was in the process of completing their master's degree but was doing this with their own resources and time.

- There was a yearly appraisal schedule for staff. For the 2017-18 financial year, 100% of staff had received an appraisal, although two of these had been completed outside of the target timeframe. The service had a 2018-19 appraisal schedule which was underway at the time of our inspection.

Multidisciplinary working

Staff worked together as a team, both internally and with external providers, to benefit patients.

- We observed the sonographers and DIAs working together effectively to maximise patients' care and procedure experience.
- The service liaised closely with GPs and the local community trust to ensure the referral and follow up process for patients was smooth and efficient. If sonographers were concerned about any results from any scans then they would contact the patient's GP on the same day over the phone to relay their concerns and to recommend the patient for further scans.

Seven-day services

- Services were available Monday to Friday from 9am to 5pm to meet routine service and capacity. In circumstances of higher volume of patients the service offered evening sessions to accommodate this, for example with the increased demand in October 2018. However, there were no plans to increase hours on a routine basis, for example to accommodate patients who had difficulty booking time off work.

Health promotion

- There was limited involvement of patients in the planning and delivery of their care, given the nature of the service provided.

Consent and Mental Capacity Act

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

- All staff had received training on mental capacity as part of their yearly mandatory training. They were aware of what to do if they had concerns about a patient and their ability to consent to the scan.
- There were processes to ensure patients consented prior to procedures. On arrival into the service, patients were given an information leaflet on what to expect during and after the scan and a patient consent form to sign. Staff told us they would not perform any scans unless the consent form had been completed. We reviewed four consent forms and saw they were all complete and signed.
- The service would only have patients referred if the referrer had no concerns about a lack of capacity. If staff had concerns about capacity then they would refer the patient back to the local hospital who would complete the necessary capacity assessments. This was part of the exclusion and inclusion criteria developed with the community trust.
- Diagnostic Healthcare had an up-to-date corporate consent policy which was available to staff on their intranet.

Are diagnostic imaging services caring?

Good

We rated caring as **good.**

Compassionate care

Staff displayed a kind and compassionate approach and communicated with patients in a caring way.

- Staff were kind, compassionate and respectful in their interactions with patients and their relatives. For example, they took the time to ensure patients were comfortable and to reduce any anxiety; staff kept voices low within the clinical environment, to reduce the risk of others overhearing.
- Patients were made aware of who staff were and why they were seeing them. The provider was compliant with National Institute for Health and Care Excellence QS15 (Patient experience in adult NHS services), as patients were introduced to the sonographer and

were made aware of their role and responsibilities. We observed staff introducing themselves to patients and explaining what their role was. Staff names were displayed on name badges.

- The service asked patients to complete a feedback survey after their scan. The results of this at the Colchester location showed that, out of 1,337 responses received from October to December 2018, there was a 96% patient satisfaction rate.
- We had concerns that the environment did not allow for maximum respect for privacy and dignity. This was because the busy and cramped waiting area meant it was not always possible for patients to speak to the receptionist without being overheard, although the service was running at unusually high demand on the day of our inspection, to help the CCG from breaching on ultrasound patient turnaround times. Also, it was not clearly labelled on clinic doors when the room was in use, so if another member of staff wanted to check, they would knock on the door. This could be disruptive to a clinic where the patient was anxious or distressed.

Emotional support

Staff provided emotional support to patients to minimise their distress.

- Staff displayed a supportive approach when treating patients and could give examples of how they had supported patients who were particularly anxious to try and help them feel at ease.
- Staff received training in breaking bad news as part of their induction and as part of the yearly mandatory training. Staff also had access to a support line if they required someone to talk to in confidence following difficult conversations with patients. They could refer patients to support services if requested.
- We had concerns that sonographers may not take a consistent approach to whether to share concerning results from scans because of a lack of policy or guidance on this. One sonographer told us they chose not to break bad news as they felt it was more appropriate that the GP explain the findings of the scan to the patient. They also felt the environment was not well suited to sensitive conversations as there was no dedicated separate room for this and patients had to walk back through the waiting area to leave the service.
- We discussed the discussions of concerns with patients with the service leads, who told us that sonographers could choose to discuss concerns if they felt it was within their scope, but that if there was a clear case of 'bad news' sonographers would leave this to the GP. We were concerned that this could lead to inconsistencies in sonographers' practice as it was not specified in service policy whether sonographers should 'break bad news' or refer it to the patient's GP to discuss with the patient.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

- Patients were provided with information before and during their appointment which helped them understand what was happening throughout the procedure.
- Patients were encouraged to ask questions during the procedure and the sonographer told us that talking with the patients through the procedures helped to manage their anxiety.
- We observed three patient scans and saw staff took the time to ensure patients understood the process. For example, a sonographer explained to a patient why one scan needed to be done with a full bladder and the next one with an empty bladder.

Are diagnostic imaging services responsive?

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

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

Diagnostic imaging

- Bookings were made, managed and delegated by the provider's patient service team based at the provider's headquarters in Manchester. Bookings were then delegated by staff at the headquarters to the Colchester location in accordance with key performance indicators, staffing levels capacity, and the service's exclusion and inclusion criteria.
- There was a service level agreement with the local acute NHS trust to provide anomaly scans to patients under the NHS. The service did not offer services to private patients or self-referrals; all bookings were made under the service's contract with the local community trust.
- Each appointment was scheduled for 20 minutes. We observed three appointments and saw this was sufficient time for the ultrasound scan to be completed because the DIA was able to record notes and observations in real time as the sonographer performed the scan.
- The service was planned and delivered as a community service. The provider had four locations nationally, one of which was Colchester. Each location carried out scans at the location itself but the provider at head office level also oversaw a minority of work performed at a community hospital to help meet demand in this area.
- There was an off-site patient service team (based at the Manchester head office) who worked across the provider's locations, and were contactable 24 hours a day to answer questions on information about clinics, directions and preparations for the scans.
- The service did not offer out-of-hours appointments, for example, for patients who found it difficult to take time off work.

Meeting people's individual needs

The service took account of patients' individual needs.

- The provider had an equality and diversity policy which was written in accordance with national best practice to help staff meet patients' cultural, communication, physical and psychological needs. All staff were trained on their induction and annually to deliver a service which was compliant with the Equality Act 2010.
- The service did not scan any patients with complex needs or learning disabilities. Patients with complex needs would be scanned at the local NHS hospital.
- The service had the facilities to scan patients with a high BMI as long as they were independently mobile, could access the clinic, and did not weigh over 180kg as this was the limitation of the clinic couches.
- Translation services were available to patients whose first language was not English. Staff were made aware at the time of booking if patients required translation services.
- There was access to video sign language translation services; staff were made aware at the time of booking if patients required sign language video services.
- Where possible, the service provided a sonographer of the same gender to undertake a scan if requested by the patient. Chaperones were available if the patient requested, and all sonographers worked with a diagnostic imaging assistant in each clinic so they were not working alone. The radiographer performing the DEXA scans worked alone so chaperones were more commonly used for these scans.

Access and flow

People could access the service in a timely way.

- Referrals were made by the patient's GP under the contract with the local clinical commissioning group (CCG). The service had a set of exclusion and inclusion criteria. Patients were able to access the service if they were 16 or over, NHS patients, able to transfer themselves onto the scanning couch unaided, and requiring one of the following scans: p. However, we were told of examples where patients had mistakenly been referred by their GP and did not meet the criteria; for example, a bariatric patient had been referred and did not meet the inclusion criteria for the service and had to be refused their procedure on the day. We were told these were reported as incidents and the service contacted the patient's GP to explain why they were not eligible and to re-emphasise the inclusion and exclusion criteria.
- Two days before the patient's appointment the patient received an automated text to remind them of their scan, location and preparation. Patients that didn't have

a mobile number, or for whom the text was not successfully delivered, were contacted by phone. They also explained what to expect on the day and patients could ask any questions.

- If patients did not attend (DNA) they were invited to attend a further appointment and if they not attend the second appointment either they were discharged back to their GP. Between October and December 2018, there were 293 instances of DNA.

  There were 173 instances where the appointment was changed by the service provider and the patient was moved to a more appropriate appointment within the service provider to accommodate a specific need. There were 46 instances of patients cancelling their appointments as the appointment was no longer required.

- Upon arrival to the service, patients checked in at the front desk and took a seat in the waiting room until called to the room by the diagnostic imaging assistant. Appointments were 20 minutes in length which we saw was sufficient time. Staff said they did not often have issues with delayed lists.

- The service had a target referral to treatment (RTT) time of five days for urgent ultrasound referrals and 14 days for non-urgent referrals. We reviewed RTT performance from June 2018 to December 2018. For urgent referrals, the service had achieved an average of 77% RTT within five days; this ranged between 27% in October 2018 to 96% in August 2018.

- The registered manager explained that in October 2018 the service unexpectedly received 200 referrals more than in the previous three months and an increase in urgent demand due to providing additional support to the local clinical commissioning group (CCG) that month. This adversely affected their RTT performance. Following the initial impact, they were able to increase capacity in November and December 2018 to meet the increased demand. For routine referrals, the service had achieved 100% within the same timeframe. For dual energy x-ray absorptiometry (DEXA) scans, the service had an RTT window of four to six weeks and was 100% compliant with this in December 2018. They were also 100% compliant with the five-day reporting target for DEXA scans.

- Scanning and reporting processes ensured prompt responses. Sonographers wrote the report, following a scan, directly into the electronic patient record system and this was sent to head office and the patient's GP within one working day. Where there were clinically urgent findings, a provisional report was sent to the referrer to notify them of any significant concerns and the sonographer would also call the patient's GP on the same day to ensure they received and checked the report as a matter of priority.

- Within the report there was a reminder that if a patient was to be forwarded to another provider, the images should be accessed through the NHS exchange portal for images to help the secondary care clinician to continue with their investigation without the need to repeat scans. Arrangements were made to ensure a clinician could speak directly to a member of the provider's clinical team.

- The service had a picture archiving and communication system (PACS) whereby images were uploaded directly from the clinic to the archive for immediate onward transfer to secondary care if required.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with staff.

- Diagnostic Healthcare had a corporate complaints and compliments policy which was up to date in electronic copy; however, the hard copy that was available we reviewed on our inspection was an out of date version. This copy stated it was due for review in August 2018 so it was five months out of date for review by the time of our inspection.

- The policy outlined the time frame for complaints to be investigated and a full written response was to be sent to the complainant within ten working days. Complaints were dealt with by a compliance manager at head office.

- There were processes to ensure patients and their relatives could make a complaint or raise concerns and were aware of how they could do this. There was

an email address and telephone number patients could contact and this information was displayed on the service's website and on leaflets in the waiting area.

- From June 2018 to January 2019, the service received eight complaints. These were a combination of complaints from both patients and their consultants. In the complaints log there were actions documented such as sending a letter of apology and holding a discussion with the relevant member of staff. However, there was no evidence documented on the log of sharing learning and actions among the wider staff group which meant there was a risk that opportunities for improvement could be missed.
- The service had an electronic patient survey application which received any comment, complaint or compliment on a live system. The system sent an automated email with the survey results for any patient that provides comments, making service managers aware straight away so they could implement any actions. All feedback forms were analysed automatically, broken down by team, site and pathway, and presented on a dashboard. The patient services team and clinical site manager used this to monitor the service, identify learning and to continue areas of good practice. Information from this was shared with staff.
- The service had identified a theme in patient feedback that patients found it difficult to find the clinic because their appointment letter stated 'Colchester Clinic' but the sign outside the building stated 'Diagnostic Healthcare'. As a result, the service changed the appointment letter to guide them to 'Diagnostic Healthcare Facilities - Colchester Clinic' which made it clearer for patients to understand and find the location.

Are diagnostic imaging services well-led?

Requires improvement

We rated well led as **requires improvement.**

Leadership

Managers had appropriate skills and staff felt supported by service leads, but we had concerns about the processes for interim leadership cover when the site manager was away.

- Senior leadership were based at the provider's headquarters in Manchester. This included the registered manager for the service, who was also the registered manager for the provider's three other locations.
- There was a clinical site lead who was a sonographer who was on site four days a week and reported directly to the registered manager. Staff reported this person was very accessible and provided good support and leadership and that they could approach them with any queries or concerns.
- The clinical site lead was not on site on the day of our inspection, but we were able to carry out an interview with them and the registered manager over the phone after the inspection. However, while they were off site there was a lack of clear 'interim' leadership or management. We were told that one of the diagnostic imaging assistants essentially covered this role for the day while they were away but they had no additional training for this and this structure was not clearly defined. Although, if the site lead was at the Manchester headquarters we were told they were easily contactable by phone or email.
- In the last staff survey in 2015, 88% of staff working across Diagnostic Healthcare said that there was a strong management team. However, this was not broken down by site, was out of date and carried out before Colchester had been added as a site.

Vision and strategy

There was limited evidence of a clear vision and strategy at local level to outline steps for targets to achieve or continuous development, although there was a general vision at provider level.

- At provider level, Diagnostic Healthcare's vision was 'To provide first class diagnostic imaging that exceeds our service commitments and customer expectations. To put the patient first, to understand the benefits our

efforts make to patients' lives and the responsibility we have for their care and recovery. To provide the resources to support every member of our team to provide healthcare that makes a difference.'

- We requested the local vision and strategy for the Colchester site. The service provided a statement of the aims and objectives of the DEXA and ultrasound services. These were 'to aid early diagnostics and avoid the need for unnecessary referral to Secondary Care, or to support the shift of activity in to a Primary Care setting' and 'to provide an excellent patient experience during all parts of the process'.
- There was no future strategy to outline targets, aims and areas for development and improvement in the service.

Culture

There was a generally positive culture within the service and staff enjoyed their work.

- Staff worked closely and communicated in an open and positive way with one another.
- The registered manager and site clinical lead worked to promote an open culture and staff felt they could be open with managers. The registered manager visited each of the provider's sites at least once a month to engage with staff and observe their work.
- There were summer and Christmas events held provider-wide for staff as a social activity.
- All independent healthcare organisations with NHS contracts worth £200,000 or more are contractually obliged to take part in the Workforce Race Equality Standard (WRES). Providers must collect, report, monitor and publish their WRES data and act where needed to improve their workforce race equality. A WRES report was produced for this provider including data from April 2017 to March 2018.
- Diagnostic Healthcare had a clear action plan following the results of the report with clear timescales of likely completion.
- There was clear ownership of the WRES report within the provider management and governance arrangements, which included the plan to take the WRES action plan to be considered by the board.

Governance

The service had a provider wide governance framework based at their head office.

- Governance staff and structures were based at the Manchester head office and not at location level. There was a Clinical Governance Committee who reported directly to the board of Directors. The clinical governance committee was overseen by three lead radiologists for DEXA, ultrasound, and MRI and a medical director. It was also attended by the compliance manager.

  Clinical governance meeting minutes were recorded in a word document format with review of previous action items. A monthly management meetings minutes which were attended by all senior management and clinical leads
- Information from the Clinical Governance Committee was then shared with the clinical lead for each region, who in turn would share verbally and via email with site level staff where it affected their site.
- The clinical site lead attended a monthly regional manager meeting where each lead shared their local updates. There was no formal meeting for the Colchester staff but any updates from these meetings would be relayed to staff by the clinical site lead, through emails. Service leads acknowledged it was a challenge, due to the structure of separate regional teams, trying to get staff together in the same day.
- The clinical site lead also had weekly meetings with the registered manager. These were a more informal way of updating the registered manager but the summaries from these meetings showed discussion of the service performance and any issues specific to site level. For example, at one meeting in January it was raised that the radiographer working in the DEXA room had requested a protection screen. He was aware it was not required due to the level of radiation occurring in the room as advised by the provider's radiation protection adviser, but would feel more comfortable if it was there. The documentation from the next meeting showed that this protection screen had been delivered to the site.
- Due to some of the concerns we had in relation to the lack of a local comprehensive risk register, clear local

strategy for the near future, and concerns around the DEXA room, we were not assured governance processes were sufficiently robust to ensure issues at site level were overseen and managed consistently at the head office level.

- At provider level, there was a team of 20 staff based at head office who provided corporate and administrative functions for all the sites operated by the provider including managing bookings and correspondence with GPs and hospitals and reviewing and storing the end of day reports submitted by all sites.
- Diagnostic Healthcare had a number of leads at provider level that staff could contact if they required more specific expertise. The service had leads in: information governance, Caldicott guardian, senior information risk owner, accountable emergency officer, safeguarding lead, mental capacity act and deprivation of liberty lead, prevent lead, freedom to speak up guardian, communication and data protection officer. Staff were aware of the leads and how to contact them. We saw a list of these leads in hard copy behind the reception desk on site.
- The service had service level agreements to describe the requirements of the contracts they held. Performance against the contracts was not discussed comprehensively at the monthly clinical governance meetings, but the registered manager told us this was because it required more regular attention, so performance issues against contracts that were raised would generally be resolved on a local basis by the operational team on a weekly basis.

Managing risks, issues and performance

Not all risks identified were captured on the risk register and staff could not identify their main risks for the Colchester location specifically.

- We requested a copy of the risk register specific to the Colchester location but this only contained one risk, in relation to potential breaches of confidential data. This was following a complaint about a data protection breach that had occurred already. It was not comprehensive and did not include target dates for compliance. There was no specific named person to manage the risk as it stated it was the responsibility of the provider's administration. It was also not clear that information and action on any potential risks were shared among all staff to ensure they were aware and to help reduce the risks.
- Service leads were not readily able to explain the local risks for their service. We were concerned that current local risks were not being closely monitored, including but not limited to the lack of space in the waiting area and the lack of policy around breaking bad news. However, when we raised the individual issues to the service, the service leads were proactive in implementing measures promptly to respond to and manage the risks, and were responsive to the feedback we provided.
- There was a provider wide risk register with risks for the organisation as a whole, but this did not include target dates for risk mitigation. There was a 'completion date' column but this had not been ticked off for any of the risks documented. There were names leads for each risk, who were all members of the senior and corporate team. There were 30 risks included in total, including for example, the cost of new equipment and litigation risks.
- Risks on this provider register were graded from one to five for impact and probability; these were then multiplied to obtain an overall risk rating. There were two risks with the highest possible rating of 25. We were not assured that the control measures in place clearly reflected a mitigation for the risk.
- The service had an automated operations ticketing system which enabled tracking of operational issues such as stock requests and maintenance requests etc. This allowed remote staff to have a clear understanding of the status of any issues they had logged such as faulty equipment.

Managing information

- Referrals were made electronically by the local NHS GPs. These would be received by the Diagnostic Healthcare head office in Manchester and reviewed for patient details, the type of request and the clinical indication and then scheduled accordingly into the Colchester site's schedule, where it would then appear for local staff.

- Following the sonographer review of the scan, patients were asked to contact their GP to get the scan's result which was sent electronically within 24 hours to their referrer GP.
- All patient records were stored electronically and paper patient consent forms were scanned and securely destroyed.
- All staff working in the service had undertaken data security and awareness training as part of their mandatory training. Staff we spoke with understood their responsibilities around information governance and risk management.
- The only risk specified on the local risk register for Colchester was in relation to information governance, following an incident in July 2018 where a letter had been sent to the wrong address and opened by someone who was not the patient. Appropriate actions had been taken, namely a reminder to the member of staff who had made the error of the importance of ensuring accurate information, although it did not state that the reminder had been shared among other staff as well, to reduce the risk of similar data breaches occurring in the future.

Engagement

There was some evidence of provider engagement with patients and staff, although we had concerns about the systems to ensure staff were consistently engaged at local level.

- Diagnostic Healthcare had twice yearly provider-wide face to face meetings. The staff we spoke with on the day of inspection had not yet had the opportunity to attend these because of the length of time they had been employed so far by the service. However, the registered manager clarified that at the December 2018 provider meeting, two DIAs and the receptionist attended from Colchester alongside the site clinical lead.
- Due to the spread of locations of staff working for Diagnostic Healthcare, staff received a weekly email which included any provider updates and learning, and a quarterly electronic newsletter.
- There were no team meetings taking place among operational staff at site level. Staff and managers told us this was because of the difficulty of grouping all staff together as they were booked to work on different days of the week and did not have a dedicated time scheduled before or after their working day for staff meetings. However, the team did use email and mobile apps to update each other which staff and managers confirmed worked well.
- There was a staff survey conducted every three years at provider level. The last survey was completed in 2015 which meant they were overdue their staff survey. As the Colchester site had only been operational since 2018, their own staff satisfaction and feedback was not a part of those survey results. There were no additional staff surveys carried out at local site level.
- The service used patient feedback forms to engage with patients and provider offered prizes to be won for the site that achieved the highest number of questionnaires filled in by patients. The patient feedback application they used allowed results to be analysed automatically and broken down by location, which could then be used to share results with staff and could be included in appraisals.

Learning, continuous improvement and innovation

There were limited examples of learning and improvement and no formal document to set out steps towards continuous improvement and development.

- We asked service leads about their main focus for improvement, innovation and development at site level. Their main focuses included improving and developing their DEXA contracted work as it had only just started in January 2019; maintaining and improving their current standards of care. However, these were not documented in any vision or strategy documents for the service or shared with staff.
- Although we had identified some concerns on inspection, notably in relation to infection prevention and control and the required labelling of the DEXA radiation environment, the registered manager was proactive in addressing these issues and provided us with assurances, which are detailed in the relevant sections under the 'safe' domain. This was evidence of learning and improvement in response to areas of concern. The service had not had any internal or external reviews in the year preceding our inspection.

Requires improvement

Diagnostic imaging

- There was limited evidence of systems to encourage staff to make suggestions for improvement and development and to then act on these. For example, the lack of space and crowded waiting room was raised as a concern to us but had not been escalated for monitor and review to service leads.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The service must ensure consistent compliance with infection prevention and control (IPC) processes and policies and ensure staff are aware of these.
- The provider must ensure any member of staff working in the dual energy x-ray absorptiometry (DEXA) room is familiar with the local rules to support radiation protection, and ensure these local rules are accessible.
- The provider must ensure they have a radiation warning trefoil sign displaying 'x-ray' and 'controlled area' at the entrance to the DEXA room, in line with their own report and recommendations and to ensure a safe environment where radiation is taking place.
- The provider must ensure all staff are aware of and confident with using the correct process and policy for incident reporting.

Action the provider SHOULD take to improve

- The provider should improve the layout of the environment to ensure patients can have private and potentially sensitive conversations.
- The provider should implement a formal records audit at local level
- The provider should ensure that all risks to the service are captured on the risk register and are specific to the Colchester site.
- The provider should consider increasing and improving systems for more regular staff feedback and engagement.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment There was a lack of compliance with best practice and local policy in hand hygiene specifically in the DEXA clinic room. The radiographer was not always using hand gel between patients and did not have hand gel or hand washing facilities in the DEXA room at the time of our inspection. Staff working in the DEXA room did not know where the local rules for the DEXA room were and was not able to confirm they were aware of what they entailed or whether they had signed a copy of them. This posed a risk in relation to radiation protection assurances and awareness. The service's 'Scatter Dose and Shielding Report/ Operator Dose and Recommendations' specified that should be 'as a minimum a radiation trefoil sign should be provided at the door entrance and include the words 'xray' and 'controlled area'. There was no trefoil sign at the entrance to indicate a warning of radiation at the time of our inspection.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance We had concerns that systems and processes for incident reporting were not sufficiently clear to staff. A sonographer and DIA told us there was a book to record incidents, in hand written form, stored in the staff office which was not in line with policy or what managers had told us.

This section is primarily information for the provider

Requirement notices

This was not in line with service policy and what managers told us, which was that the correct process was to complete an online form which was sent to the head office and the registered manager and staff to also informed the clinical site lead directly.

Service leads were unsure of the reasons for the discrepancy in staff awareness of the process when we raised it with them, although they took immediate steps to address this.