Fastrack Scan

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	Inadequate
Are services safe?	Inadequate
Are services effective?	
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Inadequate

Overall summary

Fastrack Scan is operated by Ecospirito Ltd. The service is mobile and provides dual energy x-ray absorptiometry (DEXA) scans from a 7.5 tonne mobile unit.

We inspected diagnostic imaging services, which is the only service provided.

We inspected this service using our comprehensive inspection methodology. We carried out a short-notice announced inspection on 2 April 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 to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

Summary of findings

Services we rate

We have not previously inspected this service. At the inspection on 2 April 2019, we rated this service as **Inadequate** overall.

We found areas of practice that were inadequate:

- Staff did not have the skills and training to keep people safe from avoidable harm and to provide the right care and treatment. The service did not provide mandatory training in key skills to all staff. Staff had not completed mandatory training, with the exception of the registered manager. However, there was enough staff to meet the demands of the service.
- Staff did not demonstrate an understanding of how to protect patients from abuse. Staff had not completed safeguarding training on how to recognise and report abuse.
- The service did not have processes to control infection risk well. Staff were not compliant with best practice for hand hygiene, in accordance with national guidelines. There was no infection prevention and control policy in place. Audits were not carried out and there were no cleaning schedules in place.
- The provider did not have suitable premises. There were no handwashing facilities in working order. Environmental risk assessments had not been completed. Out of date consumables were stored in the first aid kit. However, we saw evidence that scanning equipment had been serviced within the last 12 months.
- Arrangements were not in place to assess and manage risks to patients. Risks associated with radiation were not displayed. Local rules were not dated, displayed, or signed by all staff and they were not reflective of current guidance. Staff did not have the appropriate training to manage deteriorating patients.
- There was no clear process for managing incidents. Incidents were not investigated and details of discussions about incidents were not recorded. There was no evidence that lessons were learned and discussed with the team.
- Care and treatment provided was based on out of date national guidelines and standards. There was no process in place to ensure staff were following guidance. There were limited policies in place, no audits were carried out by the provider and no peer reviews had been undertaken.
- The service did not monitor the effectiveness of care and treatment and was therefore unable to identify and act upon areas that required improvement.
- There was no evidence that staff were competent for their roles. Staff's work performance was not appraised and supervision meetings were not held with them. This meant that staff were not supported to be competent in their roles and the effectiveness of the service was not monitored.
- Staff did not understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They had not received any training and written consent was taken without risks associated with radiation being explained.
- Staff did not always communicate information about the scan and what it entailed with patients and those close to them. Risks associated with undertaking scans, whilst low, were not always communicated to patients.
- The service did not always take account of patients' individual needs. Staff described some exclusion criteria, but this was not formally documented.
- The service did not have a complaints policy or process in place and patients did not know how to raise a complaint. Therefore, we could not be assured that the service treated concerns and complaints seriously, investigated them and learned lessons were shared with all staff.
- While the registered manager had the skills, knowledge, and experience to perform DEXA scans, they had not establishedsuitable and effective policies and procedures to fulfil all of the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). The service did not have managers at all levels with the

Summary of findings

right skills and abilities to run a service providing high-quality care. Leaders had no awareness of the employment checks and training that were required to keep patients safe.

- There was no vision for what the service wanted to achieve and workable plans to turn it into action.
- The culture was not focussed on safety and quality. There were no mechanisms in place for providing staff with the appropriate training or sharing of information.
- There was a lack of governance arrangements in place. The limited arrangements that were in place were not adequate to ensure high standards of care could be maintained.
- We were not assured that effective systems were in place to identify, reduce and eliminate risks, and to cope with both the expected and unexpected.
- While the provider used electronic systems with security safeguards, it did not always collect, manage and use information well to support its activities.
- There was no evidence of engagement with patients outside of the scan appointment. Views and experiences of patients were not collected, and therefore the service was unable to shape and improve the service based on feedback.

We found a limited number of areas of good practice:

- Staff kept accurate records of patients' demographics and scans, and transferred them appropriately to referring clinicians.
- Staff undertook scans for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff had the ability to minimise patients' anxieties about the scan, if required.
- People could access the service when they needed it.

Following this inspection, we formally notified the provider that their registration in respect of carrying out a regulated activity was suspended for eight weeks, under Section 31 of the Health and Social Care Act 2008. The notice of urgent suspension was given because we believed that a person or persons will or may be exposed to the risk of harm if we did not take this action. The letter included the concerns we identified during this inspection. In order for the suspension to be lifted, we must be assured that a person or persons will not be exposed to the risk of harm when we inspect the service again. On the basis of this inspection, the Chief Inspector of Hospitals has recommended that the provider be placed into special measures.

We also 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 notice(s) that affected Fastrack Scan. 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	Inadequate 	We rated the service as inadequate overall. We rated the service inadequate for safe and well-led because we believed that a person or persons will or may be exposed to the risk of harm, and there were insufficient processes in place to ensure that the quality and safety of the service was maintained. We rated the service as requires improvement for responsive because whilst people could generally access the service when they needed, the service did not take account of people's individual needs. We rated the service as good for caring because feedback from patients was generally positive and we observed some kind and compassionate interactions during our inspection. We do not currently rate the effectiveness of diagnostic imaging services.

Summary of findings

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Fastrack Scan

Services we looked at

Diagnostic imaging

Summary of this inspection

Background to Fastrack Scan

Fastrack Scan is operated by Ecospirito Ltd. The service opened in 2009 but was not registered with the CQC. It is a mobile scanning unit that provides DEXA scans across England to mainly self-funded patients of 15 years and above.

The service registered with the CQC to undertake the regulated activity of diagnostic and screening procedures in May 2018. The manager had also been registered with the CQC since May 2018.

The service also offers private scans to sports teams. We did not inspect these services.

We have not previously inspected or rated this service

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a specialist advisor with expertise in diagnostics and screening. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

Information about Fastrack Scan

Fastrack Scan is a mobile scanning service. They provide dual-energy x-ray absorptiometry (DEXA) to measure bone mineral density. Facilities are contained within a seven and a half tonne lorry and include one DEXA scan room, and a seated waiting area. The service is registered to provide the following regulated activities:

- Diagnostic and screening procedures.

Patients can self-refer or they can be referred by a clinician.

The service is contracted to deliver a DEXA scanning clinic from a number of independent healthcare locations across England. They travel to the independent hospitals and park the lorry carrying the DEXA scan in the car park, where they see patients. The provider told us they see six to 10 patients per clinic list. In addition, the service is provided to a number of sports teams on an ad-hoc basis, as and when required.

At the time of our inspection, the service employed three members of staff; the owner, who was also the registered manager and a retired radiologist; the general manager, who was also a scan operator; and a chaperone, who was also a scan operator.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 11 months before this inspection. This was the services first inspection since registration with CQC in May 2018.

Activity (May 2018 – March 2019):

- Fastrack Scan did not keep detailed records of the number of scans performed. However, they told us they had performed an estimate of 1,760 scans on 770 patients in the reporting period.
- All patients were self-funded or covered by their medical insurance.
- Fastrack Scan did not keep detailed records of the number of clinics they cancelled. However, we were told that no clinics had been cancelled in the reporting period.

Track record on safety (May 2018 – March 2019)

- The service reported zero never events.
- The service had recorded zero incidents.
- The service reported zero serious injuries.

Summary of this inspection

- The service received zero complaints.

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?

Inadequate

We rated it as **Inadequate** because:

- Staff did not have the skills and training to keep people safe from avoidable harm and to provide the right care and treatment.
- The service did not provide mandatory training in key skills to all staff. Staff had not completed mandatory training.
- Staff did not demonstrate an understanding of how to protect patients from abuse. Staff had not completed training on how to recognise and report abuse.
- The service did not have processes to control infection risk well. Staff were not compliant with best practice for hand hygiene, in accordance with national guidelines. There was no infection prevention and control policy in place. Audits were not carried out and there were no cleaning schedules in place.
- The provider did not have suitable premises. There were no handwashing facilities in working order. Environmental risk assessments had not been completed. Out of date consumables were stored in the first aid kit. However, we saw evidence that scanning equipment had been serviced within the last 12 months.
- Arrangements were not in place to assess and manage risks to patients. Risks associated with radiation were not displayed. Local rules were not dated, displayed, or signed by all staff and they were not reflective of current guidance. Staff did not have the appropriate training to manage deteriorating patients.
- There was no clear process for managing incidents. Incidents were not investigated and details of discussions about incidents were not recorded. There was no evidence that lessons were learned and discussed with the team.

However, we also found:

- Staff kept accurate records of patients' demographics and scans, and transferred them appropriately to referring clinicians.

Are services effective?

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

Summary of this inspection

- Care and treatment provided was based on out of date national guidelines and standards. There was no process in place to ensure staff were following guidance. There were limited policies in place, no audits were carried out by the provider and no peer reviews had been undertaken.
- The service did not monitor the effectiveness of care and treatment and was therefore unable to identify and act upon areas that required improvement.
- There was no evidence that staff were competent for their roles. Staff's work performance was not appraised and supervision meetings were not held with them. This meant that staff were not supported to be competent in their roles and the effectiveness of the service was not monitored.
- Staff did not understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They had not received any training and consent was taken without risks associated with radiation being explained.

Are services caring?

Good

We rated it as **Good** because:

- Staff undertook scans for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff had the ability to minimise patients' anxieties about the scan, if required.

However, we also found:

- Staff did not always communicate information about the scan and what it entailed with patients and those close to them. Risks associated with undertaking scans, whilst low, were not always communicated to patients.

Are services responsive?

Requires improvement

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

- The service did not always take account of patients' individual needs. Staff described some exclusion criteria, but this was not formally documented.
- The service did not have a complaints policy or process in place and patients did not know how to raise a complaint. Therefore, we could not be assured that the service treated concerns and complaints seriously, investigated them and learned lessons were shared with all staff.

However, we also found:

- Services were planned in a way that met the needs of people.

Summary of this inspection

- People could access the service when they needed it.

Are services well-led?

Inadequate

We rated it as **Inadequate** because:

- While the registered manager had the skills, knowledge, and experience to perform DEXA scans, they had not established suitable and effective policies and procedures to fulfil all of the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). The service did not have managers at all levels with the right skills and abilities to run a service providing high-quality care. Leaders had no awareness of the employment checks and training that were required.
- There was no vision for what the service wanted to achieve and workable plans to turn it into action.
- The culture was not focussed on safety and quality. There were no mechanisms in place for providing staff with the appropriate training or sharing of information.
- There was a lack of governance arrangements in place. The limited arrangements that were in place were not adequate to ensure high standards of care could be maintained.
- We were not assured that effective systems were in place to identify, reduce and eliminate risks, and to cope with both the expected and unexpected.
- While the provider used electronic systems with security safeguards, it did not always collect, manage and use information well to support its activities.
- There was no evidence of engagement with patients outside of the scan appointment. Views and experiences of patients were not collected, and therefore the service was unable to shape and improve the service based on feedback.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Inadequate

Diagnostic imaging

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

Are diagnostic imaging services safe?

Inadequate

We rated it as **inadequate.**

Mandatory training

The service did not provide mandatory training in key skills to all staff. Staff had not completed mandatory training.

- The service did not provide mandatory training to staff operating the scanning machines. There were no processes to monitor non-compliance with mandatory training. We raised our concerns about this to the registered manager in our follow up letter. Following our inspection, the registered manager said they would be addressing mandatory training areas.
- The registered manager had completed mandatory training at an external independent healthcare organisation. Modules included, but were not limited to, health and safety, fire safety, and information governance. All training had been completed within the last 12 months and we saw evidence of this within the registered manager's appraisal.
- The registered manager and staff members were not aware that they required mandatory training.

Safeguarding

Staff did not demonstrate an understanding of how to protect patients from abuse. Staff had not completed training on how to recognise and report abuse.

- The service did not have a safeguarding policy for children or adults. We raised our concerns about this to the registered manager in our follow up letter.
- The service had not made any safeguarding referrals in the year prior to our inspection.
- Staff had not completed training in safeguarding adults and safeguarding children, with the exception of the registered manager who had undertaken safeguarding adults and children level two. The service had carried out a small number of DEXA scans on young people aged 15 and over. There was no lead for safeguarding and staff did not have access to a level three children's safeguarding lead. We raised our concerns about this to the registered manager in our follow up letter.
- Staff we spoke with did not understand their roles and responsibilities regarding safeguarding vulnerable people. Staff could not explain safeguarding arrangements and who they would report issues to, to protect the safety of vulnerable patients. However, scan operators were aware that bruising of the skin could potentially be a type of physical abuse and would therefore be a safeguarding concern. We raised our concerns about this to the registered manager in our follow up letter.
- Staff told us they had not had to raise any safeguarding concerns to date, despite giving an example of when they had seen a potentially vulnerable child.
- There was a summary note that the registered manager had produced following safeguarding adults and children level two training that they had undertaken at an external independent healthcare organisation. This contained some relevant guidance

for staff to recognise and report any potential safeguarding concerns. However, there was no process in place to ensure staff had read it or to evaluate their knowledge. The guidance did not contain any local telephone numbers for staff to contact such as the local multi-agency safeguarding hub (MASH).

- There were no arrangements for checking all staff were fit to work with vulnerable adults and children. Essential checks had not been carried out on all staff members. The service did not carry out a Disclosure and Barring Service (DBS) check on all appointed staff. DBS is the process by which employers can check the criminal record of employment candidates. We raised our concerns about this to the registered manager in our follow up letter.
- The registered manager had a current DBS certificate which demonstrated the checks had been carried out. Essential checks for one staff member had not been carried out since 2009. One member of staff did not have a DBS in place. We raised our concerns about this to the registered manager in our follow up letter. Records of DBS checks were not kept. We found the DBS certificate in a box file, which was stored in an unlocked cupboard of the mobile unit.

Cleanliness, infection control and hygiene

The service did not have processes to control infection risk well. Staff were not compliant with best practice for hand hygiene, in accordance with national guidelines. There was no infection prevention and control policy in place. Audits were not carried out and there were no cleaning schedules in place.

- There was no infection prevention and control policy in place.
- Staff were not compliant with best practice for hand hygiene, in accordance with National Institute for Health and Care Excellence QS61 (Infection prevention and control). NICE clinical guideline 139 recommends that an alcohol-based hand rub should be used for hand decontamination before and after direct contact or care. Direct contact or care refers to face-to-face contact with patients. We raised our concerns about this to the registered manager in our follow up letter.
- Whilst an alcohol-based hand rub was available, staff did not use it between episodes of patient care.
- There were no suitable handwashing facilities for the service. A hand wash basin was available but was not used. Staff told us the sink ran stagnant water from the tank in the mobile unit. This meant there was a risk of legionella to both staff and patients. This had not been identified as a risk or any action taken. We raised our concerns about this to the registered manager in our follow up letter.
- Personal protective equipment such as gloves and aprons were available, and were stored in a cupboard. However, these would not typically be used when performing DEXA scans.
- Flooring throughout the mobile unit was maintained and visibly clean. However, flooring in the scanning room was not in line with national requirements ('Health Building Note (HBN) 00-10 Part A: Flooring', Department of Health, 2013). There was no continuous return between the floor and the wall in clinical areas, as set out in the HBN requirements. This meant that cleaning of the edges (there were no skirting boards) could be difficult. However, as no invasive clinical procedures were carried out in this area, there was very little risk of infection from blood or other bodily fluid spillages.
- Small carpeted floor mats were used next to the bed, as some patients removed their shoes for the scan. We were told they were hoovered regularly but there was no recorded evidence of this. They were visibly clean at the time of inspection. As no invasive clinical procedures were carried out in this area, there was very little risk of infection from blood or other bodily fluid spillages.
- We were told that the waste management and cleaning was the responsibility of the DEXA scan operators.
- Staff told us the equipment was cleaned at the end of each day. Couch roll was used and we observed that this was changed between each patient. The pillow was not washed. Staff told us this was because they covered it with couch roll.
- There were no cleaning schedules in place to ensure regular cleaning was carried out at the appropriate time. For example, we were not assured that daily floor, surface and fixture cleaning and quarterly machine/ chemical cleaning of hard floors were undertaken. We

were told that deep cleans consisted of an operator scrubbing the floor monthly, but we found no evidence to confirm this had occurred. We raised our concerns about this to the registered manager in our follow up letter.
- The service had reported no healthcare acquired infections in the last 12 months.
- Audits for infection prevention and control, including for environmental cleanliness and hand hygiene practice, were not undertaken. We raised our concerns about this to the registered manager in our follow up letter.
- One of the DEXA scan operators wore an overcoat when driving the mobile scanning vehicle, and setting up the equipment for use. We were told this was to prevent contamination. Staff were bare below the elbow of the arm.
- Waste, such as used couch roll, was disposed of in a household waste bin. This was then emptied at the end of each day into larger external waste bins. Staff did not wear gloves or aprons to perform this task.

Environment and equipment

The provider did not have suitable premises. There were no handwashing facilities in working order. Environmental risk assessments had not been completed. Out of date consumables were stored in the first aid kit. However, we saw evidence that scanning equipment had been serviced within the last 12 months.

- The mobile unit was a seven and a half tonne lorry which had been converted and was now used for the provision of DEXA scans. There were three steps leading into the vehicle with a portable step placed at the bottom. There were two areas; a scanning area; and a reception area used as a kitchen and waiting area, with a small table and two chairs. There was a door that could be closed to separate the scanning area and the reception area.
- There was a stairlift however we did not see this in use. At the time of our inspection, there was no evidence that the stairlift had been serviced or an environmental risk assessment had been undertaken or that staff had adequate training. However, following the inspection, the registered manager told us that a risk assessment to the stair lift had been undertaken and servicing was completed in August and October 2018.
- The stairs to the van were steep. No environmental risk assessments had been undertaken. We raised our concerns about this to the registered manager in our follow up letter.
- The environment in which the scans were performed was well-lit and arranged for the purpose of its use.
- There were no handwashing facilities in working order at the time of our inspection.
- An external company completed the servicing of the DEXA scanning machine. Staff confirmed it had been serviced annually. Documentation we reviewed indicated it had been serviced in September 2018. If faults arose, staff said they were able to call out engineers to assess and perform repairs. We did not see any equipment servicing history prior to 2018.
- Electrical portable appliances had been safety tested the day prior to our inspection to ensure they were safe for use. We reviewed three pieces of electrical equipment and found all equipment displayed stickers to show the date of testing.
- The first aid kit contained 19 items that were out of date, despite staff telling us that this had been replenished the week before inspection. These included sterile bandages and eye patches, some of which had expiry dates dating back to 2010. We highlighted this to the registered manager. We were told the out of date items would be disposed of appropriately and a new first aid kit would be purchased. We raised our concerns about this to the registered manager in our follow up letter.
- There were cupboards to store other consumable items of equipment, such as couch roll.
- There were two fire extinguishers. One of which was positioned in the scanning room and one in the kitchen/ waiting area. They had been serviced within the last 12 months.
- Waste was handled and disposed of in a way that kept people safe. Staff used the domestic waste bin to dispose of couch roll which had been used during scans.

Assessing and responding to patient risk

Arrangements were not in place to assess and manage risks to patients. Risks associated with radiation were not displayed. Local rules were not dated, displayed, or signed by all staff and they were not reflective of current guidance. Staff did not have the appropriate training to manage deteriorating patients.

Diagnostic imaging

- Staff told us that the service only provided scans to patients who were low risk, and patients who were physically well and could transfer themselves to the couch without support. However, this was not outlined in the service level agreement with an independent healthcare organisation. There was not a set of exclusion and inclusion criteria for DEXA scans. We raised our concerns about this to the registered manager in our follow up letter.
- Staff told us that patients who lacked mental capacity would not be seen. There was no guidance, exclusion criteria or policy for this. We raised our concerns about this to the registered manager in our follow up letter. Staff told us that if patients arrived that didn't meet this criteria, they would not be scanned and the referring clinician would be informed. Staff did not keep a record of how often this happened.
- Staff did not have a clear understanding of what local rules were. We were provided with documents that were titled 'local rules' that had been developed by staff, however, they were not dated, not displayed, not signed and referenced out of date guidelines. This was not in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and Ionising Radiations Regulations (IRR) 2017 which state that every employer engaged in work with ionising radiation must, in respect of any controlled area or, where appropriate having regard to the nature of the work carried out there, any supervised area, make and set down in writing such local rules as are appropriate to the radiation risk and the nature of the operations undertaken in that area. We raised our concerns about this to the registered manager in our follow up letter.
- A document we reviewed titled 'local rules' stated that "patients who are pregnant must identify to the operator that they are pregnant". A questionnaire was completed by patients prior to undergoing a DEXA scan. The form required a patient's signature to show that they "(I) consent to the DEXA scan and if female confirm (I) am not pregnant". Therefore, staff were made aware of women who were pregnant. However, there was no way of ensuring women who may be pregnant always informed a member of staff before they were exposed to any radiation in accordance with IR(ME)R. Pregnant women and women who may be pregnant were not made aware of the risks associated with radiation.
- The registered manager for the service was also the radiation protection supervisor (RPS), despite some documents stating that the general manager/scan operator was the RPS. They could be contacted by telephone. The contact information was not displayed nor included in the local rules for the DEXA scanning area, which was not in line with best practice. However, the scan operators did know the RPS's telephone number.
- There were no signs or information in the waiting area informing people about areas or rooms where radiation exposure takes place. This meant there was a risk that patients and their relatives were not aware of the risks associated with exposure to radiation. We raised this during our inspection and staff told us they did not display information on the walls as they did not wish to damage the interior of the lorry.
- Operators did not have basic life support (BLS) training or first aid training. There was no deteriorating patient policy. Staff did not have the skills to care for a patient in the event that they became unwell or required resuscitation. There were no arrangements in place to care for a deteriorating child, despite seeing children. Therefore, we were not reassured that staff could manage the deteriorating patient safely. We raised our concerns about this to the registered manager in our follow up letter. Following our inspection, the registered manager said the general manager/scan operator was booked on to a cardiopulmonary resuscitation (CPR) course at the end of April 2019.
- We were provided with a copy of out of date advanced life support guidelines issued by the Resuscitation Council in 2005, despite staff not having advanced life support training, or life support training of any other level. There was a mobile two-way radio system in place for use in an emergency. One radio stayed in the mobile unit and the other was kept behind the reception of the hospital site they were at that day. Staff told us that if a patient deteriorated whilst in their care, they would use the radio system to inform the hospital, follow the guidelines provided and commence chest compressions. Once a member of staff from the hospital arrived, they would dial 999. We were not assured that patients would be safe should they require basic life support.
- Staff were not undertaking all recommended operator checks by the Society and College of Radiographers (SCoR) before the scan was carried out. This can sometimes be known as the pause and check process.

Staff did not always confirm patient ID using unique identifiers. We raised this during our inspection and there was some confusion around what unique identifiers were. Therefore, we were not assured that adequate patient ID checks were completed prior to the scans. Staff did not always ensure patients understood the examination that was being undertaken.

- Staff told us that in the event of unexpected or significant findings at the point of scanning, they would inform the referring clinician.
- There were employers' procedures in place which were meant to protect staff from ionising radiation. For example, staff wore an electronic personal radiation dosimeter to measure and detect radiation levels they have been exposed to. We saw no evidence of the personal dosimetry audit reports. Dose rate measurements had not been recorded since 2018 and were not routinely monitored or audited.
- There were processes in place for staff to follow in the event of overexposure and unintended exposure.
- Staff were able to explain what they would do in the event of a fire. These instructions were also displayed in the mobile unit.

Staffing

Staff did not have the skills and training to keep people safe from avoidable harm and to provide the right care and treatment. However, there was enough staff to meet the demands of the service.

- There were three members of staff who worked at Fastrack Scan; the registered manager, and two DEXA scan operators. One of the DEXA scan operators was also appointed as the general manager.
- The registered manager told us they were present at the mobile unit for approximately 50% of the work carried out by the service.
- Staff had not completed an induction. This was not in line with the staff handbook. Induction checklists and evaluation sheets were not provided to staff. This was also not in line with the staff handbook.
- There was no evidence of formal DEXA training for the operators since 2009, which was a theoretical training course for IR(ME)R operators, and did not include any practical training on the equipment. We raised our concerns about this to the registered manager in our follow up letter.
- There had been no staff sickness in the last 12 months.
- There were no cover arrangements in place for when staff were off work on holiday or sick. The registered manager told us that shorter holidays of three days at any one time were encouraged to prevent service disruption. This meant there was a risk that staff did not get a choice in how long they were off work for.
- There were no staff vacancies at the time of our inspection. The provider did not use any bank, agency or locum staff.
- The registered manager was a retired radiologist. The registered manager could be contacted for advice at all times when they were off site.
- There were no risk assessments to minimise the risks associated with lone working, nor was there a lone working policy.
- Staff had scanned three children in the last 12 months. However, they did not have access to a registered children's nurse that could provide advice at all times, in line with national guidance issued by the Royal College of Nursing (RCN): Defining staffing levels for children and young people's services (2013). The registered nurse does not have to be on site, however they must be reachable for advice at all times, for example, by telephone.

Records

Staff kept records of patients' demographics and scans, and transferred them appropriately to referring clinicians.

- The service used an electronic system to record patient's name, age, weight and height. During the clinic we observed, the DEXA scan operators input the patient's details in to the electronic system prior to scanning the patient. This meant there was minimal delay between record completion and scanning.
- All patients referred by independent healthcare providers, provided a list of patients who were being scanned. Once the scan was completed, a hard copy

was provided to the referring clinician at the end of each clinic. A separate copy was stored in the provider's electronic system which was secure, backed up and password protected.

- Patient history forms were scanned into the general managers laptop, and the original copy was returned to the referring clinician with a print out of the scan. The laptop was on site during clinic lists. It was stored in the general managers home at all other times.
- Records were clear, up-to-date and easily available to all staff providing care. Scan images were backed up to a server monthly.
- 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 and highlighted to staff.

Medicines

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

Incidents

There was no clear process for managing incidents. Incidents were not investigated and details of discussions about incidents were not recorded. There was no evidence that lessons were learned and discussed with the team.

- There was no clear process in place to manage incidents. The provider did not have a policy for managing incidents. A book titled 'significant events' was used to record a summary of both risks and incidents. Due to the small size of the service, the provider told us they discussed incidents as soon as they occurred. We saw no documented evidence of this.
- There were three entries recorded in the 'significant events' book from the last 12 months. None of the three entries were incidents. They were risks to the service.
- Not all incidents were reported. For example, there was a road traffic incident that had led to repair works. This was not included in the 'significant events' book.
- From April 2018 to March 2019, the provider reported no never events or serious injuries. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- Staff had some understanding of the duty of candour and told us they would always be open and honest with patients if anything went wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not had any incidents that met the threshold for implementing the duty of candour.
- The registered manager was aware of their responsibility to report notifiable incidents to the Care Quality Commission (CQC) and other external organisations, but said they had not had reason to report any incidents to date.

Are diagnostic imaging services effective?

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

Evidence-based care and treatment

Care and treatment provided was based on out of date national guidelines and standards. There was no process in place to ensure staff were following up to date guidance. There were limited policies in place, no audits were carried out by the provider and no peer reviews had been undertaken.

- The provider's DEXA protocols were written by the registered manager. There was no system to ratify and review protocols or policies.

Inadequate

Diagnostic imaging

- Policies and procedures were based on out of date national guidelines. For example, radiation protection arrangements were based on Ionising Radiation Regulations (IRR) 1999 instead of IRR 2017. We raised our concerns about this to the registered manager in our follow up letter.
- Some guidelines were not relevant to the service. For example, we saw out of date guidelines such as the Resuscitation Council guidelines issued in 2005 for advanced life support. Staff did not have advanced life support training and therefore this was inappropriate and was not based on up to date guidance. Some guidelines and policies referred to the medical director's responsibilities. There was no medical director employed by the service. We raised our concerns about this to the registered manager in our follow up letter.
- There were limited policies in place. Policies that were in place, were not adhered to. For example, the radiation protection policy states "local rules will contain the name of the employer, radiation protection advisor (RPA) and supervisor (RPS), a list of controlled areas, working arrangements and contingency plans. Relevant working arrangements will be displayed in each controlled area". Local rules were not displayed, nor were they based on up to date guidelines and best practice. They did not include the name of the employer, the RPA, or the RPS. This was also not in line with best practice. We raised our concerns about this to the registered manager in our follow up letter.
- There was no process in place to ensure best practice and new guidance was identified and implemented. Practice was not audited against guidelines, and there was no clinical audit programme in place. Participation in benchmarking clinical audits was also not carried out. Staff took no action to monitor the safety and effectiveness of the service provided and therefore were unable to understand where improvements were required.
- The service did not use 'Pause and Check' which was produced by the Society and College of Radiographers to reduce the number of radiation incidents occurring within radiology departments.
- The use of diagnostic reference levels (DRLs) were not audited. There was no process in place to ensure the correct dosage was given to children when they were scanned. We raised our concerns about this to the registered manager in our follow up letter. However, the DEXA scan operator noted the diagnostic reference level for each investigation.

Nutrition and hydration

- There were no nutrition services for patients that attended. However, staff had access to and could provide patients with a selection of refreshments (tea, coffee and water).

Pain relief

- Patients were asked by staff if they were comfortable during their appointment, however no formal pain level monitoring was undertaken as these procedures were pain free.

Patient outcomes

The service did not monitor the effectiveness of care and treatment and was therefore unable to identify and act upon areas that required improvement.

- Information about the outcomes of people's care was not collected or monitored. There was no use of audits to drive service improvements or monitor the safety and effectiveness of the service.
- The service did not record or monitor the time between when a referral to the service for a scan was received and that scan being performed.
- Audits of the quality of the images were not undertaken.
- The number of patients seen and scanned was not routinely monitored. However, staff were able to obtain the number of patients seen and the number of scans performed using the electronic system.

Competent staff

There was no evidence that staff were competent for their roles. Staff's work performance was not appraised and supervision meetings were not held with them. This meant that staff were not supported to be competent in their roles and the effectiveness of the service was not monitored.

Diagnostic imaging

- There was no evidence that staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, took on new responsibilities and on a continual basis.
- There was no process to identify the learning needs of staff to cover the scope of their work. The DEXA scan operators had not received an appraisal in the last 12 months or at any time since employment commenced. The registered manager had been appraised at an independent healthcare provider in 2018.
- Staff competencies were not assessed as part of the recruitment process, at induction, through probation, and then ongoing as part of staff performance management.
- There was no evidence of formal training for the operators since 2009, which was a theoretical training course for Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) operators, and did not include any practical training on the equipment.
- There were no equipment training records available for staff who operated imaging equipment. No staff had equipment competencies documented. There was a risk that staff may not have been competent to safely operate the equipment used.
- Staff had not received formal training in radiation administration. There was no process for regular supervision provided in accordance with legislation set out under IR(ME)R. There was no process to monitor scanning performance.
- Staff had not been trained and therefore did not have the appropriate skills to recognise and treat a deteriorating adult or child.
- Poor or variable performance was not identified and managed. For example, staff and the registered manager were not aware of non-compliance with best practice guidelines for hand hygiene, IRR and IR(ME)R.
- The service did not provide a mandatory and statutory training programme for staff. This meant there was a risk that staff did not have the relevant knowledge and competencies required.
- One of the DEXA scan operators also drove the mobile unit. They had the appropriate driving qualifications to do so.

Multidisciplinary working

Due to the size and nature of the service, there was limited opportunities for multidisciplinary working.

- Staff working in the service reported good relationships with external partners and undertook scans for a private provider at a number of locations. There were opportunities for staff to contact referrers for advice and support. However, we saw no evidence of ongoing monitoring of the service which should have been shared with external partners in line with the service level agreement in place.
- Staff told us they would escalate concerns verbally to the referring clinician.

Seven-day services

- The service operated on an ad-hoc basis. Staff were flexible and would provide a service as and when they were required.
- The registered manager was available by telephone out of usual office working hours.
- No clinical emergency patients were scanned within the service. The service did not offer any emergency appointments but would see patients at short notice if required.

Health promotion

- Information leaflets such as understanding your DEXA bone density scan were available. These leaflets included information about osteoporosis and fractures.

Consent and Mental Capacity Act

Staff did not understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They had not received any training and consent was taken without risks associated with radiation being explained.

- We could not be assured that staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental

Capacity Act 2005 and the Children's Acts 1989 and 2004. Staff had not received training on mental capacity. They were not aware of what to do if they had concerns about a patient and their ability to consent to the scan. They were not familiar with processes such as best interest decisions.

- There was no consent policy. Consent was not obtained in line with best practice. For example, the Society and College of Radiographers (SCoR) recommend that it is essential for consent to be confirmed or obtained to ensure that sufficient information has been given. We were not assured that informed consent was achieved. We did not observe all relevant risks were explained to patients.
- There was a patient history questionnaire which each patient completed prior to have a scan. The consent to the DEXA scan was given by the patient signing a clause which said "I consent to the DEXA scan, if the patient was female they also confirmed 'I am not pregnant". There was a risk, given that patients were not given an explanation of risks prior to the scan, that they may not declare they are pregnant. We raised this with the registered manager, who told us they were considering developing a new consent form.

- Staff told us they would not scan a patient if they appeared confused or did not understand the scanning process. Staff were unable to provide an example of when they had refused a patient who was confused. Staff had not received mental capacity act training and there was no guidance in place for managing patients who lacked capacity. We raised our concerns about this to the registered manager in our follow up letter.

Are diagnostic imaging services caring?

Good

We rated it as **good.**

Compassionate care

Staff undertook scans for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

- We observed two DEXA scans performed and spoke with three patients, following the inspection, about their experience of the service. Without exception, feedback was positive about their experience, and the kindness and care they received. One patient told us they found the staff 'nice and friendly' and another told us they were made to feel relaxed.
- Privacy and dignity was maintained during scans. If patients were required to undress, staff left the scanning area. There was a door between the scanning area and the kitchen/waiting area. This was usually kept closed during scans. Patients did not wait within the waiting area of the mobile unit whilst a patient was in the scanning area. They waited within the reception area of the independent provider.
- There was a chaperone available for both males and females.
- We observed a staff member accompanying patients from the waiting area of the hospital to the mobile unit for their scan. The staff member was kind and held an umbrella for the patient to ensure they did not get wet in the rain whilst walking to mobile unit.
- During the scans we observed, staff were friendly and helpful. However, we observed an insensitive comment was made to a patient. This was unintentional, but further contributed to the concerns raised about the knowledge and training of staff.
- There was no process to collect feedback from patients. Comments and compliments were also not recorded.

Emotional support

Due to the nature of the service provided, staff did not generally have to provide emotional support. However, staff had the ability to minimise patients' anxieties about the scan, if required.

- Staff had the ability to provide support and minimise their anxieties about the scan, if required.
- Patients were not informed of any abnormalities they may have identified during the scan. Any concerns were escalated to the referring clinician who then discussed these with the patient.

Understanding and involvement of patients and those close to them

Inadequate

Diagnostic imaging

Staff did not always communicate information about the scan and what it entailed with patients and those close to them. Risks associated, whilst low, were not always communicated.

- Staff communicated with patients clearly, so they understood the instructions once within the mobile unit. Patients were given verbal instructions, information about how long the scan would take and what was required from them. However, patients were not made aware of the risks associated with radiation. There was no explanation of what the scan entailed. Patients were not informed of why they needed to be weighed and measured prior to having the scan performed.
- Staff told us they welcomed patient's parents, carers and relatives. They were able to offer them a seat within the mobile unit.
- Patients were informed of the next steps in their care. For example, the referring clinician would be in touch with the patient to discuss the scan images and further care or treatment.
- The registered manager had developed information leaflets about DEXA scans. However, one patient told us they had to request information, and that the information was technical and difficult to understand. It was not referenced, and therefore we could not be assured it was from a reliable source. Patients were not handed leaflets, but they were available.

- Patients we spoke with said the referring clinician had provided them with information about the scan. One patient said they were not aware that radiation was involved.

Are diagnostic imaging services responsive?

Requires improvement

We rated it as **requires improvement.**

Service delivery to meet the needs of local people

Services were mainly planned in a way that met the needs of people.

- Fastrack Scan provided DEXA scanning for a private provider at a number of locations across England. They also provided DEXA scans to a number of sports teams, care homes and GP practices. The mobile unit provided services to the private provider through a service level agreement (SLA).
- We were told that progress in delivering services in line with the SLAs was monitored by the private provider through the radiation protection advisor report and other agreements as set out in the SLA. For example, the SLA set out that DEXA scans must be printed and provided to the provider within one hour, and monthly reports must be produced. Whist we saw evidence that scans were printed, we saw no evidence that they were provided within an hour or that monthly reports were produced.
- Some, but not all, locations monitored patient feedback. However, staff told us they did not receive information about the patient feedback from the provider. The service did not collect their own.
- The unit operated on an ad-hoc basis. They would provide a service as and when they were required. This meant that patients had a greater choice of appointment times and could access services during evenings and weekends.
- Patients who required a hoist could not be seen. There was a manual handling policy which was not dated. This stated that patients could not be lifted onto the scan table. However, they would scan patients who were in a wheelchair.
- The facilities, whilst small, were appropriate for the services that were planned and delivered. There was no toilet or changing facilities. However, not all patients were required to undress for the scan. Patients could access toilet facilities inside the independent hospital.
- As the unit was mobile, the service was generally accessible. When the service was provided in the car park of an independent provider, car parking for patients was free.
- Information was not given to patients before appointments. Staff said this was the responsibility of the provider they had an SLA with. During our

inspection, one patient appeared surprised that they were being scanned in a mobile unit, parked in the car park. It was clear that the patient had not been advised of this beforehand.

- Appointments were not confirmed in writing. The number of patients who did not attend (DNA) their appointments was not monitored.
- Staff were unable to explain what reasonable adjustments had been made for children and young people. However, children's parents were able to stay in the scanning area with the child.

Meeting people's individual needs

The service did not always take account of patients' individual needs. Staff described some exclusion criteria, but this was not formally documented.

- Staff told us they were unable to scan patients who were unable to manoeuvre themselves up on to the scanning couch. They also said they would not scan patients who lacked mental capacity or appeared confused. Staff were unsure of what the weight limit for the couch was. However, there was no formally documented exclusion criteria outlining which patients the service would not scan.
- Despite this, reasonable adjustments were made so that patients in wheelchairs could access and use services on an equal basis to others, such as a stair lift and an extended appointment slot.
- We were not assured that adjustments would be made for a patient living with a learning disability. However, we were told longer appointments could be arranged.
- There was no formal access to interpreters for patients who did not speak English.
- The registered manager had developed patient information leaflets about DEXA scans, and these were kept on the table in the kitchen area of the mobile unit. However, the information was technical and difficult to understand. It was not referenced from a reliable source. Patients were not given leaflets.
- Patients were advised about what happened after their scan. The scan operator explained that the scan would be given to their consultant and results would be discussed with the patient at their next appointment.
- The service had introduced a second scan operator who was able to act as a chaperone for female patients, if required.

Access and flow

People could access the service when they needed it.

- Whilst staff told us that patients had timely access to scans, this was not monitored.
- As the service was mobile, patients who required a more urgent scan date were offered the choice of alternative locations that they could travel to for a sooner appointment.
- Appointments generally ran to time; staff would advise patients of any delays as they signed in. At the time of our inspection, all patients were seen on time. Patients who were running late, were seen when they arrived.
- Scans were printed immediately after they were performed. They were provided to the referring clinician at the end of the clinic list. This was not in line with the SLA, which stated that scans should be provided within one hour of completion.
- Patients could access the service at a time to suit them. Staff made arrangements to start the list earlier or later, when required. Clinic lists were developed by the private provider that the service had an SLA in place with. All other bookings were managed by the service manager. We did not see evidence of the appointment system used.
- Staff told us that appointments were only cancelled when necessary. For example, adverse weather. However, cancellations were not monitored.

Learning from complaints and concerns

The service did not have a complaints policy or process in place and patients did not know how to

raise a complaint. Therefore, we could not be assured that the service treated concerns and complaints seriously, investigated them and learned lessons were shared with all staff.

- The service said they had not received any complaints in the last 12 months.
- There was no complaints policy or procedure. Staff did not receive training in managing complaints. However, the registered manager had attended conflict resolution training and had given their training notes to staff. There was no evidence that staff had read the training notes.
- There was no information displayed about how to raise a complaint. Patients we spoke with did not know how to raise a complaint about the service, but said they had no reason to complain. They said they would contact the referring service provider if they had any concerns.
- We could not be assured that complaints would be investigated and learning shared. This was because there was no policy, procedure or guidelines to follow.

- We spoke with a manager from an independent healthcare provider who had a service level agreement in place with Fastrack Scan. They told us they had not received any concerns from patients about the service.

Are diagnostic imaging services well-led?

Inadequate

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

Leadership

While the registered manager had the skills, knowledge, and experience to perform DEXA scans, they had not established suitable and effective policies and procedures to fulfil all of the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). The service did not have managers at all levels with the right skills and abilities to run a service providing high-quality care. Leaders had no awareness of the employment checks and training that were required.

- The service was led by the registered manager who was a retired radiologist. They had previous experience in leading a DEXA service in an NHS trust. The day to day management of the mobile unit was led by a general manager who was also a scan operator.
- Despite the experience of the registered manager, leaders did not have the skills, knowledge and experience they required to lead and manage the service safely and effectively. For example, there was no evidence that the general manager/scan operator had received the appropriate practical training to operate the scanner. The registered manager had developed a very limited number of policies, which were of poor quality, contained limited information and based on out of date guidance and regulations.
- Leaders did not understand the challenges to quality and sustainability, therefore they had not identified the actions needed to address them. For example, they were unclear about the requirements for staff to be appropriately trained and where to source adequate training from.
- They had not established suitable and effective policies and procedures to fulfil the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).
- Leaders were visible and approachable. The registered manager was available by telephone during each clinic. The scan operator was able to contact the registered manager at all times, if required.

Vision and strategy

There was no vision for what the service wanted to achieve and workable plans to turn it into action.

- There was no documented vision or strategy. The service had not developed any values.
- Staff told us they hoped to expand the service and employ radiographers with recognised training experience. They recognised that an appropriate induction process would be required.

Culture

Inadequate

Diagnostic imaging

Whilst staff were friendly and welcoming, the culture was not focussed on safety and quality. There were no mechanisms in place for providing staff with the appropriate training.

- The registered manager and staff were friendly and welcoming. They were committed to providing a caring DEXA scanning service to patients.
- Staff felt they were respected and valued by the registered manager. Staff were positive about their roles.
- There were no mechanisms in place for providing staff with development and training. Appraisals were not completed. This meant that staff were unaware of areas of development they needed, and training required, to lead the service, and scan patients. There were no plans in place to address this at the time of our inspection.

Governance

There was a lack of governance arrangements in place. The limited arrangements that were in place were not adequate to ensure high standards of care and oversight could be maintained.

- There was a lack of effective governance framework to support the delivery of quality patient care. There was no clear oversight of the day to day working of the service. For example, the service failed to identify risks associated with lack of radiation protection signs, compliance with IR(ME)R and IRR 2017, lack of compliance with infection prevention and control practices, lack of practical competencies and lack of training. This meant that the governance system in relation to the management of risk did not operate effectively to ensure that leaders have clear oversight of the risk of harm to patients and their relatives. We raised our concerns about this to the registered manager in our follow up letter.
- Due to the small nature of this service, there were no governance or team meetings. However, we were told staff discussed any relevant topics when they saw each other or over the phone, usually weekly. These conversations were not documented.
- There were no personnel files for staff members. We saw no evidence of qualifications, references, and employment history. Not all staff had undergone the Disclosure and Barring Service (DBS) checks. Leaders were not aware of the importance of these checks, despite scanning children and vulnerable adults. We raised our concerns about this to the registered manager in our follow up letter.
- We could not be assured that audits of scans were undertaken, as they were not documented. We raised our concerns about this to the registered manager in our follow up letter.
- The provider had not identified what training in key skills their staff needed. Nor did they have a system in place to ensure they were up to date with their own training. For example, there was no training schedule and mandatory training key skills was not, and had not previously been, provided. We raised our concerns about this to the registered manager in our follow up letter.
- There were very limited policies and procedures in place. For example, there was no infection prevention and control policy or safeguarding policy. The policies that were available contained insufficient information, referenced out of date guidelines, such as historic Resuscitation Council guidelines, were not relative to the service and were not dated or signed. Some policies made reference to the roles and responsibilities of the medical director, however the service did not have a medical director in post. There were no mechanisms in place to review key documents such as local rules, policies, and protocols. We raised our concerns about this to the registered manager in our follow up letter.
- Service level agreements (SLAs) were not signed. Staff were not clear about the purpose of SLAs.
- Not all staff were clear about their roles and responsibilities. These were not clearly defined. There was some confusion regarding the responsibilities of the registered manager and the general manager/scan operator.
- There was no systematic filing system. We requested a number of documents during our inspection and were provided with several box files. Information was in no particular order and contained a variety of radiation protection documentation, patient identifiable information, and information about staff members.

- The governance and filing of documentation relating to radiation protection had been highlighted as a recommendation in the radiation protection advisor (RPA) report in both March and September 2018, but no action had been taken by the provider. Following our inspection, the registered manager told us they had spent some time retrieving documents for the IR(ME)R file.

Managing risks, issues and performance

We were not assured that effective systems were in place to identify, reduce and eliminate risks, and to cope with both the expected and unexpected.

- There was not an effective process in place for reviewing and managing compliance with IR(ME)R 17 and IRR 17 regulations. For example, recommendations set out in the radiation protection advisor report had not been actioned. We saw no evidence of the personal dosimetry audit reports. Dose rate measurements had not been recorded since 2018 and were not routinely monitored or audited.
- No action had been taken to ensure that the service was compliant with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017. There were no up-to-date IR(ME)R and local rules required under the Ionising Radiation Regulations (IRR) 2017 in place, and documents that were in place did not always relate to the service for example included references to a dental practice. Local rules are required under IRR to protect staff and visitors by controlling the area of work. Local rules had not been signed. We saw no evidence of diagnostic reference levels (DRLs), therefore we were not assured doses to patients were optimised and kept 'as low as reasonably practicable'. We raised our concerns about this to the registered manager in our follow up letter.
- There were no assurance systems or performance monitoring systems in place. Safety and quality audits were not undertaken in relation to records, infection prevention and control, and environment. There was a lack of awareness of improvements that were required due to insufficient monitoring. We raised our concerns about this to the registered manager in our follow up letter.
- No audits were carried out to monitor the safety and effectiveness of the service, and there were no quality assurance measures in place. Patient feedback wasn't collected by the service. We were told that the registered manager audited scans carried out by the general manager/scan operator, but they were not documented. We raised our concerns about this to the registered manager in our follow up letter.
- We found there was little understanding or a process to identify, understand and address potential risks within the service. There was a book titled 'significant events'. We saw three incidents and risks recorded. There was no evidence that the three risks had been discussed, mitigated or action taken. These included:
  - Risk of bad weather resulting in cancelling a clinic list.
  - Risk of an independent provider withdrawing a contract.
  - Risk of delays to location caused by road traffic accidents/incidents.
- Environmental risks and safety risks had not been identified. For example, we identified several risks during our inspection, such as steep stairs to climb on to the vehicle and the lack of training provided and undertaken. At the time of our inspection they were unable to evidence risk assessments that had been carried out. The one risk assessment we saw related to an office risk assessment, which was irrelevant to the service being provided. We raised our concerns about this to the registered manager in our follow up letter.
- We saw no evidence that the impact on quality had been assessed in preparation for expanding the service.
- Back up emergency generators were in place in the event that the system failed. However, we saw no evidence of this as monthly testing of the generator was not formally documented.

Managing information

While the provider used electronic systems with security safeguards, it did not always collect, manage and use information well to support its activities.

Diagnostic imaging

- It was unclear how the terms and conditions were communicated to service users. We did not see any evidence of the terms and conditions. They were not available on the website and there was no information displayed in the mobile unit on payments and fees.
- Scan images were easily accessible and were kept secure. Hard copies of scans were provided to the referring clinician. Self-referring patients also received a hard copy of their scan. Electronic systems were password protected.
- The general manager/scan operator was responsible for storing and backing up images. They told us they copied all scan images onto a secure hard drive monthly. The hard drive was stored securely at the managers home but there was no limit for how long they would keep the hard drive.
- During our inspection, staff were unable to specify the set retention period for the length of time scan images, patient details, and medical history could be stored. There was no policy in place for which set out the retention periods and the information stored was not regularly reviewed, deleted or anonymised. This meant there was a risk that the provider was holding information for long periods of times that they no longer needed. This is not in line with the General Data Protection Regulation (GDPR) 2018, despite the provider claiming, on their website, they were compliant with the GDPR requirements. Following our inspection, the registered manager informed us they retain data for ten years.
- Fastrack Scan had been registered with the Information Commissioners Office since April 2016.
- The registered manager had completed information governance training. However, the general manager/ scan operator had not.
- Records of the number and types of scans were not routinely monitored. This information was taken from the electronic system and collated upon request.

Engagement

There was no evidence of engagement with patients outside of the scan appointment. Views and experiences of patients were not collected, and therefore the service was unable to shape and improve the service based on feedback.

- Views and experiences of patients were not gathered by the provider. This meant the provider was unable to shape and improve the service based on feedback from patients.
- Staff were actively engaged. Their views were reflected in the planning and delivery of services.

Learning, continuous improvement and innovation

Processes were not in place to enable staff to identify when something went wrong. We saw no evidence of learning, promoting training or quality. However, staff members had been involved in a research project.

- The registered manager did not undertake any continuous improvement or innovation. For example, the registered manager did not undertake any audits or peer reviews.
- We escalated some concerns identified on the inspection to the registered manager and the general manager/scan operator during our inspection. Following our inspection, we sent a letter detailing our concerns and notifying the registered manager of the decision to suspend the service for eight weeks.
- The registered manager had participated in recent studies looking at the likelihood of osteoporosis amongst jockeys and rugby players.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

On the basis of this inspection, the Chief Inspector of Hospitals has recommended that the provider be placed into special measures.

- The provider must ensure they are compliant with Ionising Radiation (Medical Exposure) (IR(ME)R) Regulations 2017. Regulation 17 Good governance (1) (2)(a)(b).
- The provider must ensure they have, and staff adhere to, policies and best practice guidance that will help to prevent and control infections. In addition. the provider must maintain a clean environment, that facilitates the prevention and control of infections. This includes adequate hand washing facilities. Regulation 12 safe care and treatment (1), (2)(h).
- The provider must ensure that staff have the qualifications, competence, skills, experience and training to do so safely. They must have a mandatory training programme in place and a system to ensure mandatory training is completed when required, including safeguarding training adults and children for all staff working in the service. Regulation 17 Good governance (1) (2)(a)(b)(d).
- The provider must ensure recruitment procedures are established, operated effectively, and the relevant information gathered in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 19 Fit and proper persons employed (1), (2)(a).
- The provider must ensure that consumables have not exceeded their expiry date, and are safe to use. Regulation 12 safe care and treatment (1), (2)(e).
- The provider must ensure that staff using the equipment have the training, competency and skills needed. Regulation 12 safe care and treatment (1), (2)(c).
- The provider must ensure they assess the risks to the health, safety and welfare of people using services. This includes environmental risk assessments. Regulation 12 safe care and treatment (1), (2)(a)(b).
- The provider must ensure there is a documented patient eligibility criteria and exclusion criteria in place, adhered to, and available to all staff. Regulation 17 Good governance (1) (2)(a)(b)(c)(d).
- The provider must ensure there are systems or processes in place to assess, monitor and improve the safety and quality of the service. Improvements should be made without delay once they are identified. Regulation 17 Good governance (1) (2)(a)(e)(f).
- The provider must ensure policies, procedures, local rules are up to date, accurate and properly analysed and reviewed. Regulation 17 Good governance (1) (2)(d).
- The provider must ensure they maintain securely records relating to people employed. This includes employment checks, training, and competencies. Regulation 17 Good governance (1) (2)(d).
- The providers must ensure that their audit and governance systems are effective. Regulation 17 Good governance (1) (2)(f).
- The provider must ensure there are policies and procedures in place for obtaining consent, and that they reflect current legislation and guidance. This includes ensuring patients are provided with information about the risks of radiation exposure prior to being asked for consent. Regulation 11 need for consent (1), (2), (3), (4).
- Staff must be supported to ensure they participate in statutory training, and other mandatory training. The provider must ensure staff are regularly appraised. Regulation 18 staffing (1), (2)(a).

Outstanding practice and areas for improvement

Action the provider SHOULD take to improve

- The provider should seek and act on feedback. It should be listened to, recorded and responded to as appropriate. It should be analysed and used to drive improvements to the quality and safety of services.
- The provider should ensure staff receive appropriate ongoing or periodic supervision in their role to make sure competence is maintained.

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 11 HSCA (RA) Regulations 2014 Need for consent • The provider must ensure there are policies and procedures in place for obtaining consent, and that they reflect current legislation and guidance. This includes ensuring patients are provided with information about the risks of radiation exposure prior to being asked for consent. Regulation 11 need for consent (1), (2), (3), (4).

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider must ensure there are systems or processes in place to assess, monitor and improve the safety and quality of the service. Improvements should be made without delay once they are identified. Regulation 17 Good governance (1) (2)(a)(e)(f). • The provider must ensure policies, procedures, local rules are up to date, accurate and properly analysed and reviewed. Regulation 17 Good governance (1) (2)(d). • The providers must ensure that their audit and governance systems are effective. Regulation 17 Good governance (1) (2)(f).

This section is primarily information for the provider

Enforcement actions

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 • The provider must ensure they have, and staff adhere to, policies and best practice guidance that will help to prevent and control infections. In addition. the provider must maintain a clean environment, that facilitates the prevention and control of infections. This includes adequate hand washing facilities. Regulation 12 safe care and treatment (1), (2)(h). • The provider must ensure that consumables have not exceeded their expiry date, and are safe to use. Regulation 12 safe care and treatment (1), (2)(e). • The provider must ensure that staff using the equipment have the training, competency and skills needed. Regulation 12 safe care and treatment (1), (2)(c). • The provider must ensure they assess the risks to the health, safety and welfare of people using services. This includes environmental risk assessments. Regulation 12 safe care and treatment (1), (2)(a)(b).

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider must ensure they are compliant with Ionising Radiation (Medical Exposure) (IR(ME)R) Regulations 2017. Regulation 17 Good governance (1) (2)(a)(b). • The provider must ensure that staff have the qualifications, competence, skills, experience and training to do so safely. They must have a mandatory

This section is primarily information for the provider

Enforcement actions

training programme in place and a system to ensure mandatory training is completed when required, including safeguarding training adults and children for all staff working in the service. Regulation 17 Good governance (1) (2)(a)(b)(d).

- The provider must ensure there is a documented patient eligibility criteria and exclusion criteria in place, adhered to, and available to all staff. Regulation 17 Good governance (1) (2)(a)(b)(c)(d).
- The provider must ensure they maintain securely records relating to people employed. This includes employment checks, training, and competencies. Regulation 17 Good governance (1) (2)(d).

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing • Staff must be supported to ensure they participate in statutory training, and other mandatory training. The provider must ensure staff are regularly appraised. Regulation 18 staffing (1), (2)(a).

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed • The provider must ensure recruitment procedures are established, operated effectively, and the relevant information gathered in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 19 Fit and proper persons employed (1), (2)(a).