University of Derby Clinical Services

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	Good
Are services safe?	Good
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.

Summary of findings

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

Overall summary

University of Derby Clinical Services is operated by University of Derby. The service has a reception area, separate waiting area and a clinical room containing the dual-energy x-ray absorptiometry machine.

The only service provided by this university was diagnostic imaging, more specifically dual-energy x-ray absorptiometry (DEXA) scanning. We therefore only inspected diagnostic imaging services at this location.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced visit to the service on 11 December 2018. Due to no clinical activity taking place during this unannounced visit, we completed an announced visit to the service on 18 December 2018.

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.

Services we rate

We previously did not have the authority to rate this type of service, however now we do. We rated it as **Good** overall, but **Requires Improvement** for well-led.

We found the following areas of good practice:

- There was a system and process in place for identifying and reporting potential abuse. Staff were supported by individuals with more enhanced training in safeguarding and there were clear channels of escalation which staff were aware of.
- Clinical environments were visibly clean and tidy, and were suitable and appropriate to meet the needs of the patients who attended for appointments.
- The scanning environment had appropriate signage in place and staff conducted and recorded regular quality checks of the equipment. There were local rules in place for staff to follow which were written by a suitably qualified radiation protection advisor.
- Staff conducting the scans had evidence of appropriate, in date radiation safety training.
- There was a process in place for escalating unexpected and significant findings and staff were able to provide examples of when they had followed this.
- Feedback from patients and their relatives was positive and we observed some examples of compassionate care.
- There was evidence of staff working well with multidisciplinary team members both internally and externally, with staff commenting on the good working relationships they had formulated.
- The service reported low numbers of did not attend appointments and had a process in place for following up patients who failed to attend their appointments.
- Managers were supportive and visible and staff were confident to approach them if they had concerns to escalate.
- There was a process in place to identify, assess and manage risks to the service.

However, we also found areas of practice the service needed to improve:

- During our initial inspection, staff were only mandated to complete regular training on child and adult protection and basic life support. Additional

Summary of findings

training including infection prevention and control and manual handling was completed as continuing professional development of the practitioner and not recorded by the provider. However, since our inspection the provider has informed us they intend to review the mandatory training requirements of all staff and update any supporting policies for this.

- The service had not recently conducted any quality assurance audits of the scan reports they were producing. However, information provided following the inspection provided robust actions of how they intended to address this.
- There was no infection prevention and control policy in place at the service to enable staff to adhere to correct principles and standards. We observed staff not always being bare below the elbow when providing care and treatment, although direct (hands on) patient care was minimal.
- There were governance systems in place to monitor the quality and sustainable care being provided to patients, however these had failed to identify when audits had not been conducted and when policies and procedures had not been updated to include new regulations, legislation or best practice.
- There was no system in place to provide translation and interpretation services for patients who did not speak English as their first language.

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 one requirement notice for the service to address. Details are at the end of the report.

Amanda Stanford

Deputy Chief Inspector of Hospitals (Central)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	Diagnostic imaging, more specifically the provision of dual-energy x-ray absorptiometry (DEXA) scanning was the only service provided at this location. We rated this service as good overall with requires improvement for well-led because patients were protected from avoidable harm and abuse. Care and treatment was provided based on best practice and provided by competent staff. Feedback from patients was positive and we ourselves observed positive examples of compassionate care. Patients could access care and treatment in a timely way. However, we were not assured that the governance systems in place were robust enough to safeguard high quality care and improve service quality.

Summary of findings

Contents

Good

University of Derby Clinical Services

Services we looked at

Diagnostic imaging.

Summary of this inspection

Background to University of Derby Clinical Services

University of Derby Clinical Services is operated by University of Derby. The service opened in 2005 and runs out of the clinical services department of the University of Derby. The scanning service mainly provides a service for patients living in the East Staffordshire region, however it also accepts patient referrals from neighbouring counties and has previously accepted referrals from professional athletes. All patients referred to and seen by staff at the service were adults. No children or young people were seen at this service.

The service has had a registered manager in post since February 2017 when it was first registered with the CQC.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector and an assistant inspector both of whom had undertaken the diagnostic imaging training. The inspection team was overseen by Simon Brown, Inspection Manager.

Information about University of Derby Clinical Services

The service is registered to provide the following regulated activities:

- Diagnostic and screening procedures.

During the inspection, we visited the DEXA scanning suite within the University premises only. We spoke with four staff including; radiographers, reception staff, medical staff and senior managers. We spoke with three patients and three relatives.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the first time that the service was inspected since registration with CQC in February 2017.

Activity for the service:

- Information provided by the service showed there were 405 scans performed between January and December 2018.
- All 405 scans performed were for NHS patients. No privately paying patients were scanned during this time.

University of Derby Clinical Services employed three radiographers, all of which worked on a part time basis. The service did not use agency or bank staff. The service did not use any medicines and therefore did not have an accountable officer for controlled drugs (CDs).

Track record on safety (October 2017 to December 2018)

- Zero never events
- Zero clinical incidents
- Zero serious incidents
- Zero complaints

Services accredited by a national body:

- There were no accreditations for this service.

Services provided at the location under service level agreement:

- Clinical and or non-clinical waste removal
- Grounds Maintenance
- Maintenance of medical equipment

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?

Good

We rated safe as **Good** because:

- There were processes in place to ensure patients were protected from avoidable harm and abuse. Staff knowledge of safeguarding was evident and there were clear processes for escalation.
- The scanning room was visibly clean and tidy, and staff mainly followed correct infection prevention and control practices when providing care and treatment to patients.
- The environment was purpose built and had appropriate signage for the level of risk the area posed. All equipment was serviced and maintained appropriately.
- There was an incident reporting policy and procedure in place which staff were aware of. The service had a positive approach to incident reporting and learning from all incidents.
- There was a process in place for staff to follow for unexpected and significant findings. Staff were able to provide examples of when they had used this process.
- There was a strict criteria in place for the patients who were referred to the service and staff reviewed each referral to ensure they met this criteria in accordance with current regulations.

However:

- The mandatory training structure which was in place at the time of inspection was minimal, with only three areas of training recorded by managers. All other training was considered as a staff's individual responsibility (including infection prevention and control and manual handling training). Since our inspection, the provider were reviewing their mandatory training processes and will shortly be implementing improvements.
- Staff were not bare below the elbow at all times when providing care and treatment to patients and there was no infection prevention and control policy to enable staff to adhere to correct infection prevention and control principles.
- The local rules for the service had not been updated to include the new Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) and Ionising Radiation Regulations 2017 (IRR).

Are services effective?

We rated effective as **Not rated** because:

Summary of this inspection

- Policies, procedures and guidance was mainly based on the most recent national policies, legislation and best practice guidance including those released by bodies such as National Institute for Health and Care Excellence (NICE).
- All staff had received a meaningful performance development and review (similar to an appraisal) and there was evidence of professional registration
- There was evidence of staff working well with multidisciplinary team members both internally and externally, with staff commenting on the good working relationships they had formulated.
- Staff were knowledgeable about the Mental Capacity Act (2005) and the requirements around consent.

However:

- The service had not undertaken any scan report audits for 22 months due to changes in staffing and external support. This was identified by the provider during our inspection, and information was submitted post inspection of how they planned to address this.

Are services caring?

Good

We rated caring as **Good** because:

- Patients we spoke with were all positive about the service they received and the staff who provided the service. Our own observations during the inspection supported positive interactions between staff and patients.
- There were systems in place for the service to collect patient satisfaction and feedback on a regular basis.
- Staff ensured patients received information about their scan and gave them the opportunity to ask questions.

Are services responsive?

Good

We rated responsive as **Good** because:

- Staff at the service had made a concerted effort to meet the needs of patients living with dementia, including completing additional dementia awareness training.
- The service reported very low numbers of did not attend appointments, however there was an assured process in place to manage patients who failed to attend their appointments.
- The service had a positive approach to the complaints they received (which was low in numbers) and the management of complaints.

Summary of this inspection

- The referral to scan time was routinely between two to three weeks, which was well below the average time for an acute provider.
- During the reporting period of October 2017 to September 2018 there were no cancellation of appointments for non-clinical reasons.

However:

- There were no formal processes in place to meet the needs of patients who did not speak English as their first language, despite staff telling us they had previously scanned patients who required translation services.
- The service had only just formally started to record the number of did not attend appointments each month.

Are services well-led?

Requires improvement

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

- The governance systems in place were not robust enough to identify policies and procedures which contained references to outdated regulations, legislation and best practice or a lack of scan report audits since the change in Radiation Protection Advisors.
- There were processes in place to identify, record and assess risks in the service including a University risk register. However no risks were recorded on there which were specific to the scanning department despite some risks being identified by inspectors and an additional risk of sustainability of services being identified by the staff from the service at the time of inspection.
- At the time of our inspection, the managers had minimal oversight of some aspects of the clinical setting and staff training, including mandatory training completion, infection prevention and control practices and lack of quality audits.
- There was no vision or strategy for the service at the time of our inspection, although it was acknowledged other factors were impacting on this.

However:

- There was evidence of information and issues being escalated upwards, as well as information being cascaded downwards through the system.
- There was a positive culture within the service with all staff saying they supported and respected each other, and leaders were visible and approachable.
- There was an open and honest culture within the service with a no blame approach to incidents and investigations of incidents.

Summary of this inspection

- There was evidence of patient engagement and feedback systems were in place to enable service improvements to be made.

Good

Diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

We previously did not have the authority to rate this service. However, on this inspection we did have authority to rate and we rated it as **good.**

Mandatory training

- **The service provided mandatory training in key skills to all staff, however it was down to the individual staff member to ensure they were up-to-date.**
- Managers told us the clinical staff were responsible for maintaining their own mandatory training. The elements of training which was provided for clinical staff and was recorded on the department training log was cardiopulmonary resuscitation training, adult protection, child protection, manual handling for objects and fire safety.
- Managers told us all staff had recently undertaken updated training on information governance when the new General Data Protection Regulation (GDPR) was released.
- Staff told us they were responsible for ensuring they were up-to-date with other healthcare professional mandatory training including infection prevention and control, equality and diversity, and patient handling, and they held evidence of previously completing these elements, however these were last completed in 2017 and staff were aware they would need to update themselves at some point. Staff were unaware of the frequency of updating their mandatory training and the information we reviewed did not indicate how often staff needed to complete mandatory training.
- Information received after the inspection showed the service had already started to implement changes to the mandatory training package for all staff. We were informed this would be addressed at the next clinical governance meeting which was due to take place.
- We observed evidence of staff completing training on radiation risks and the local rules. Staff told us they would discuss further training requirements regularly with the radiation protection advisor (RPA).

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.** Staff had training on how to recognise and report abuse and they knew how to apply it.
- The registered manager was the lead for safeguarding at this service and staff were aware of this. The registered manager had received safeguarding training to level two. Staff also had access to the University's safeguarding support system which had close links with the local authority. Members of staff within this team were trained to level three in safeguarding children which gave clinical staff the opportunity to discuss any concerns with someone who held more in-depth knowledge of safeguarding children.
- The clinical service had access and followed two safeguarding policies. One policy was written by the University and was a combined vulnerable adults and

children safeguarding policy. Within this policy, there were procedures for staff to follow should they suspect a patient was at risk, as well as information which aimed to remind staff of the signs and symptoms of abuse. The other policy available for staff to follow was from the local authority safeguarding board. Staff were aware of these policies and the content of them, however they had never had to report any safeguarding concerns.

- All staff had completed safeguarding vulnerable adults training (adult protection) and had also completed safeguarding children training level two (child protection). However, staff were unsure how often this training should be conducted, and the policies did not contain this information.

Cleanliness, infection control and hygiene

- **The service controlled the risk of infection.** Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. However, we did not observe any infection prevention and control (IPC) specific policy to enable the staff to comply with appropriate IPC measures.
- There were no handwashing facilities available in the immediate clinical environment where the scans were undertaken. However, staff had access to alcohol hand gel at the point of care and we observed them using this in accordance with the World Health Organisation (WHO) five moments for hand hygiene. Handwashing facilities were available near to the clinical room for staff to use if required. We observed staff were not always bare below the elbow during patient interaction, although it was noted that actual patient contact was minimal.
- Staff had access to personal protective equipment (PPE) however staff were rarely required to use PPE due to the nature of the tasks they were performing.
- Cleaning of the clinical environment was completed by the University cleaning team. Staff told us if they had any concerns, they reported it to the maintenance team and this would be rectified immediately.
- Staff from the service were responsible for decontaminating the scanning equipment. Paper towel was used to cover the scanning machine. We observed staff changing the paper towel and cleaning the scanning equipment after patient use.
- Patients with known infection control risks were not scanned at this location. Patients who were unwell at the time of their procedures with potentially communicable illnesses were advised not to attend their appointments until they had recovered.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
- The DEXA scanning suite was located in the health and social care department within the main University. There was a reception area, waiting area and clinical room which contained the scanning equipment which was designated to this service.
- The DEXA scan machine had recently been purchased and was within warranty for any malfunctions which occurred. There was a contract in place with the company to ensure regular servicing and maintenance of the scanning machine was conducted.
- Staff conducted regular quality assurance tests prior to completing any scans on patients. These were recorded electronically for auditable purposes.
- All other equipment items were provided by the University and were serviced and electrically tested by their engineering department.
- There was a radiation warning sign present on the door of the scanning room, with an additional sign informing other staff members and patients not to enter when the door was closed. However, there was no sign in place which illuminated when the scanning machine was in use. The room itself remained unlocked at all times as there was only one entrance and exit to the scanning room. A risk assessment had been conducted by the department and advice sought from the Radiation Protection Advisor (RPA) which confirmed these measures were adequate for the level of risk for the department.

- Staff had access to lead aprons in the department if they were required, however as the scan involves low doses of radiation, staff did not routinely use these. The distance away from the scanning machine the operator meant their exposure was minimal.
- Staff had access to emergency equipment in the event of a patient deteriorating during their scan. The nearest equipment was located in the reception area of the onsite GP service, opposite to where the scanning department was. Staff also told us, in the event of a patient deteriorating, security staff would be alerted to bring an additional automated external defibrillator (AED) to the department. Staff from the DEXA scanning department were not responsible for the routine checking and maintenance of this equipment.
- Staff correctly segregated clinical and domestic waste. Waste bins provided for the department were enclosed and foot operated. Waste was collected from the clinical area during the cleaning process and discarded according to University policy.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient.** They kept clear records and asked for support when necessary.
- The service did not have a policy or guidance in place for the management of a deteriorating patient, however staff told us if a patient became unwell whilst undergoing a DEXA scan, they would instantly use their basic life support skills and shout for additional help, and then would telephone for an emergency ambulance using 999. There were no emergency alarms or buzzers located within the scanning room, however staff told us this did not impact on the summoning of help in an emergency as there were always staff around to respond to a shout for help.
- In addition to staff summoning an emergency ambulance, staff also raised an internal alert using a recognised number (dialling 7777). This would prompt security staff to respond to the department with an additional AED for staff to use if required.
- The service had a strict DEXA scanning criteria which they adhered to. All referrals for a scan were reviewed by the scanning practitioner to ensure only those who were appropriate for the procedure were completed. This was in accordance with the requirements of the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R).
- The department had local rules for all staff to follow to ensure both patients and staff remained safe at all times. These local rules had been completed by an external Radiation Protection Advisor (RPA) and were regularly updated. However, at the time of our inspection, we noted the local rules referenced the now superseded Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000 rather than the updated regulations released in 2017. Information received following our inspection showed a revised set of local rules were being drafted and were due to be reviewed at the next clinical governance meeting in March 2019.
- Staff were aware of the details to access the current RPA if required, otherwise they would see them during the annual audit. Staff commented the current RPA had been in post for two years, prior to this the RPA was in that role for 13 years and they had built up a strong relationship with them. There were no concerns raised about not being able to access the current RPA. There was a staff member within the department who acted as the radiation protection supervisor (RPS) and they were suitably trained for this role.
- Staff told us all female patients under the age of 55 years would undergo a risk assessment which included details around their last menstrual period (LMP). If patients were unsure of this information or the information given was over 28 days, the staff would postpone their scan until information was received to demonstrate the patient was not pregnant.
- There was a process in place for staff to follow if they identified any unexpected or significant findings during the scan. Staff were knowledgeable of this process and were able to provide examples of when they had followed this process. Staff also told us, any unexpected findings, despite their level of seriousness would be identified on the scan report. If further follow up was required, this would be indicated and advised on the report.

Staffing

Good

Diagnostic imaging

- **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.**
- There were two diagnostic radiographers and one assistant practitioner who worked at this location on a part-time contract. One of the diagnostic radiographers was the main employee at this location, with the other two staff members providing cover for short term sickness and annual leave.
- The service had not used agency or bank staff during the reporting period of October 2017 to September 2018. This decision was made by the senior management team to manage staff absence through the use of additional part-time staff. This ensured consistency in staffing and ensured staff were knowledgeable in the policies and procedures of the service.
- No medical staff were employed by the service, and the service did not have direct access to a radiologist.

Records

- **Staff kept detailed records of patients' care and treatment.** Records were clear, up-to-date and easily available to all staff providing care.
- The service followed the Information Governance Alliance records management policy, dated July 2016. This ensure all staff adhered to the correct principles of record keeping.
- The service did not have the ability to share diagnostic results electronically at the time of our inspection. Reports were compiled by the diagnostic radiographer who was competent in reporting and these were sent to the referring practitioner.
- Senior staff told us they did not regularly share the scan pictures with the referring practitioners due to the reports being comprehensive. If there was a genuine reason why the scan images were required, they would be able to save them on to a disk which could be sent, however this would not be a usual request and there was no standard operating procedure or policy to support this practice.
- The service had previously audited the quality of the reports produced by the diagnostic radiographers. However, during our inspection we found there had been a significant period since the last audit was conducted due to the individual previously responsible leaving their position. Senior staff investigated this and provided us with an action plan of how they intended to address this which appeared robust. Staff did however comment that they had only ever received praise and compliments from referring practitioners on the quality of scan reports they had received.

Medicines

- The service did not use any medicines for their procedures.

Incidents

- **The service had processes in place to manage patient safety incidents well.** Staff recognised incidents and reported them appropriately when required. Managers had investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff would apologise and give patients honest information and suitable support. Incident reporting procedures were included in the Clinical Services Quality Management Policy which was last reviewed in November 2018.
- There were no never events reported for the service from October 2017 to September 2018. 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.
- There were no serious incidents reported for the service from October 2017 to September 2018. Serious incidents are events in health care where there is potential for learning or the consequences are so significant that they warrant using additional resources to mount a comprehensive response.
- There were no incidents IR(ME)R or Ionising Radiation Regulation (IRR) reportable incidents, reported by the service from October 2017 to September 2018. Incidents which were reportable under the IR(ME) regulations included exposures where the dose was much greater than intended.

Good

Diagnostic imaging

- Staff had not raised any clinical incidents, accidents or near misses from October 2017 to September 2018. Senior staff attributed this to a very professional member of staff responsible for conducting and reporting on the scans, the size and type of the service and number of scans they performed each week and also the strict referral criteria.
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. The duty of candour regulation only applies to incidents where severe or moderate harm to a patient has occurred.
- Staff we spoke with understood the duty of candour process and the need for being open and honest with patients when errors occur. Senior staff members were able to explain the process they would undertake if they needed to implement they duty of candour following an incident which met the requirements. We also observed patient information leaflets in the waiting room which informed them about the duty of candour and what it meant for patients.
- Information provided by the service showed there were no incidents from October 2017 to September 2018 which required the duty of candour to be implemented in accordance with the regulation.

Are outpatients and diagnostic imaging services effective?

We do not rate effective.

Evidence-based care and treatment

- **The service mainly provided care and treatment based on national guidance.** Managers checked to make sure staff followed guidance.
- Staff had access to service specific and University policies, procedures and guidance which were mainly based on current legislation, evidence-based care and treatment and best practice, which included policies and guidance from professional organisations such as National Institute for Health and Care Excellence (NICE). Staff were knowledgeable of the clinical guidelines and quality standards related to osteoporosis and the risk of fragility fractures.
- The local rules for the DEXA (dual-energy X-ray absorptiometry) scanner were completed by the external radiation protection advisor (RPA), however these were based on outdated regulations. Both the Ionising Radiation (Medical Exposure) Regulations and Ionising Radiation Regulations (IRR) were updated in 2017 and released in early 2018, however the local rules were still referring to the outdated versions. Staff were, however familiar with the new regulations and information received after the inspection has identified a new version of the local rules were now being drafted.

Nutrition and hydration

- **Due to the nature of the service, staff did not provide patients with food and drink during their appointments.**
- Patients visiting the scanning suite had access to the University's cafes which were in the main reception area.
- There was a water fountain just outside the waiting area for the scanning service which patients could access whilst waiting.

Pain relief

- **Staff did not assess and monitor patients regularly for pain.** The DEXA scan was a none invasive procedure and did not provide any pain or discomfort for patients. Any patients with a chronic pain problem was given advice from their referring practitioner around continuing with pain medication.
- During our inspection we observed staff asking patients if they were comfortable during their procedure. If patients responded they were not comfortable, staff would try to reposition them to make them more comfortable.

Patient outcomes

- **There was minimal monitoring of the effectiveness of care and treatment**.

Good

Diagnostic imaging

- The service had undergone their annual radiation protection audit in August 2018. Although there were a small number of actions identified for the service to complete, there were no serious actions impacting patients identified.
- In the most recent radiation protection audit, the Radiation Protection Advisor (RPA) had identified potential for additional DEXA specific outcome audits to be conducted. Although not specified at the time, the RPA had put an action in the audit report for them to explore what additional audits could be conducted.
- Staff told us they had previously had scan report audits conducted for quality assurance purposes, however due to staff changes and other factors this had not been conducted in the last 22 months. The registered manager provided us with information showing an investigation into this and a plan of action for rectifying this.
- Staff told us they were not required to complete any outcome measures for the clinical commissioning group (CCG) who commissioned the service. The only data the service was required to report to the CCG each month was the number of scans performed.

Competent staff

- **The service made sure staff were competent for their roles.** Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- The service used the University's development and performance review cycle for the appraisal process. Staff had regular meetings with their line managers before completing an end of year (summative) review was completed in May/June time to reflect on the staff members performance over the previous year. Staff told us these were useful and meaningful to highlight areas of further development. However, this year, staff told us they had experienced difficulties with scheduling in time for continuous professional development. Despite staff not having had the opportunity to complete their own CPD during the last year, staff acknowledged the potential for opportunity at the service due to its location and links with the University.
- Staff had recently updated their professional registration with the Health and Care Professionals Council (HCPC) and the service maintained evidence of this process on their own staff files.
- The University's head of diagnostic imaging regularly engaged with staff in the service to provide clinical supervision and support to them. Staff told us they regularly saw this member of staff and would discuss any professional matters with them if required.

Multidisciplinary working

- **Staff of different kinds worked together as a team to benefit patients.**
- We observed the local team working well to provide safe and effective care and treatment for patients who required a dual energy X-ray absorptiometry (DEXA) scan. All staff commented on how well they worked as a team despite being a small team.
- Staff told us they had a good working relationship with the Radiation Protection Advisor (RPA) despite them being an external professional who they did not have regular contact with. However, they told us if they had any concerns or required advice, they knew they could contact them at any time.
- Staff told us they had a list of routine referring practitioners with whom they had built up working relationships with over the years since the service started. Staff had previously contacted them at various times to discuss patients referred to them and this had enabled them to build up good relationships.

Seven-day services

- The service did not provide a seven-day service for patients. The service routinely scanned patients on Tuesdays only. The service was also reliant of when the University was open. During holiday periods, for example Christmas the University closed which meant that service was also closed during this time.

Health promotion

- The service had access to a wide range of patient information leaflets about osteoporosis, a condition which impacted a lot of the patients who attend the

scanning department. Staff also told us they were able to provide simple health and lifestyle advice in relation to diet, smoking and exercise and the impact this had on osteoporosis.

Consent and Mental Capacity Act

- **Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.** They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Staff told us the strict referral criteria for the location meant that they did not routinely scan patients where capacity to consent was an issue. However, staff were aware of the Mental Capacity Act (2005) as this was included within their vulnerable adults safeguarding training, which they had all completed. If staff had any concerns about a patient with regards to their capacity, they would discuss their concerns with the referring practitioner.
- All staff were aware of the requirement for patients to consent to procedures, however patients were not required to complete a formal consent form for the DEXA scan. Staff would seek informal consent (asking if they were happy to go ahead with the scan) from the patient prior to proceeding with the procedure.

Are outpatients and diagnostic imaging services caring?

Good

We previously did not have the authority to rate this service. However, on this inspection we did have authority to rate and we rated it as **good.**

Compassionate care

- **Staff cared for patients with compassion.** Feedback from patients confirmed that staff treated them well and with kindness.
- During our inspection, we observed the care and treatment of three patients and engaged with them during their time at the dual-energy x-ray absorptiometry (DEXA) scan unit. Feedback from patients and their relatives was positive with them commenting on staff's caring and respectful approach.
- Staff ensured that patients privacy and dignity was maintained during their time at the service. Only one patient was taken through to the scanning room at a time to prevent any dignity issues from arising. Any private conversations were held in the scanning room and voices lowered to prevent any breaches in confidentiality.
- The service regularly requested feedback from patients after their procedure and the service produced quarterly reports from this information. Information from the July 2018 report showed 100% of patients strongly agreed that the service they received overall and the quality of care was excellent. All responders reported they would recommend the service to their friends and family. However, it was noted that only seven patients completed a feedback form for this reporting period. Staff were aware of the low response rate and were considering ways of improving this.
- We observed staff introducing themselves to patients and explaining their role during our inspection. This was in line with the recommendations in the National Institute for Health and Care Excellence (NICE) quality standards for patient experiences in healthcare.

Emotional support

- **Staff were equipped to provide emotional support to patients to minimise their distress.** However, during our inspection we did not observe any episodes of care which required this level of support.
- Staff told us about examples where they had been required to provide emotional support to patients following scans which had identified some unexpected and significant findings.

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.**

Good

Diagnostic imaging

- We saw staff taking the time to explain all the details of their care and treatment to patients and encouraged them to be partners in their care. Staff communicated with patients in a manner they understood. We saw staff involving patients during the scanning procedure, ensuring they were comfortable at all times.
- Data from the patient feedback report supported our findings, with all patients strongly agreeing or agreeing to questions which included the procedure was explained to them in a way which they understood, the practitioner listened to what the patient said and instructions including medications, follow up care and lifestyle advice was easy to understand.
- During the scanning procedure, relatives or friends accompanying the patient were requested to wait outside of the scanning room. However, as soon as the scan was over, patients were given the option of having their relative or friend accompanying them whilst the radiographer discussed the results with them and any post scan advice (for example, health promotion advice). During our inspection, we observed the family member of a patient being asked into the room to be with the patient whilst the results were discussed.
- Patients and their relatives/friends were encouraged to ask questions about the information they received if they had not understood what they were told.

Are outpatients and diagnostic imaging services responsive?

Good

We previously did not have the authority to rate this service. However, on this inspection we did have authority to rate and we rated it 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.** The DEXA (dual-energy X-ray absorptiometry) scanning suite was within a fixed location at the local University. Patients were referred to the service by their GP or another medical practitioner, the service did not accept self-referring patients. The service worked with one main clinical commissioning group (CCG) and another provider to plan and deliver the service to a certain demographic of patients within the local counties.
- Patients using the service had access to complimentary car parking near to the entrance of the service, which was flat and easy for patients to access the building. The University was on a main transportation route for buses and there was other transportation links close by. The service did not accept referrals for patients who required transportation through a patient transport ambulance.
- Patients were usually directed straight to the area of the University where the scanning suite was located, however for patients who used the main entrance to the University, there were signs to direct patients and many staff to help guide patients where they needed to go.
- The scanning suite had their own waiting area directly outside. This was patient friendly and there was a small selection of patient information leaflets available for them to read.

Meeting people's individual needs

- **The service took account of patients' individual needs and tried to meet them.**
- Patients who were overweight were not referred to this location for their scan, they would attend the services other location where they were equipped to manage this patient group. However, staff told us if they did have a patient who had a higher body mass index (BMI) and were able to independently get to this location and needed minimal staff assistance, the scanning equipment was appropriate to take patients with a higher BMI.
- Staff were aware of the individual needs of patients living with dementia and where possible always tried to meet their individual needs. Staff had undergone dementia awareness training to enable them to better understand how best to meet their needs and always encouraged any carers or relatives to stay with the patient whilst they prepared the patient for the scan.
- The service did not have access to a translation service and did not provide patient information leaflets in

alternative languages. Staff told us the majority of their patients were English speaking, however they had previously provided care and treatment to patients who did not speak English as their first language. In these circumstances, patients brought relatives with them who were able to translate information for them. Staff were happy with this arrangement for patients to bring relatives with them to complete any translation or interpretation requirements and did not think there was any risk related to this.

- The service did not instantly have access to information leaflets for patients who had visual impairments and required larger font. Staff told us most information given to the patient after their scans was verbal, so have never experienced any difficulties with this.
- Patients with a learning disability were usually referred to the other location if they required a scan. However, staff realised the benefits of this patient group coming to this location due to the calmness compared to the other site. If there was a patient who requested to attend this location, they would ensure they worked with the patient, and any relatives or carers that attended with them to meet their individual needs.

Access and flow

- **People were restricted to set times and days that they could access the service.** However, waiting times from referral to scanning patients were in line with good practice.
- The service capacity was limited by standard rotas and patients were allocated places as they were referred. At this location, DEXA scans were only performed on a Tuesday, with scanning days also being the subject of further restriction dependant on the University holidays and closure. On occasion, the service had allocated additional scanning days when demand had increased to keep waiting times to a minimum. However, this was a relatively rare occurrence and on a planned and pre-booked basis.
- The average time patients waited from referral to scan appointment was three weeks, with some patients being allocated an appointment within two weeks of referral. There were times when patients fell outside of this time frame, however this was usually down to patient choice (unable to attend the pre-arranged appointment).
- The service did not have emergency appointments for patients who required scans at short notice, as most requirements for this type of scan were not under emergency or urgent requirements. However, staff told us there would usually be at least one appointment slot empty on each list which referring practitioners could utilise if they contacted the service directly.
- Staff told us the service had a small number of patients who Did Not Attend (DNA) their appointments, however actual figures were not available at the time of our inspection. The service had only recently started to formally capture the numbers of DNA appointments from November 2018. During this month, there had been two patients who failed to attend for their appointments. Staff told us there were on average five or six patients each month who failed to attend for their appointments.
- Staff contacted patients to ensure there were no concerning circumstances as to why they missed their appointment before rearranging their appointments. The most common cause of a patient who DNA was if the letter arrived when they are away from home on holiday. The service had no set policy or procedure for patients who continually missed their appointments.
- There were no planned procedures delayed by the service due to equipment failure or for a non-clinical reason between October 2017 to September 2018. Staff told us if they needed to cancel or delay scans for any reason they informed the patients and the referring practitioners of the delay and give them the option to accept a later appointment or to rebook with another provider.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, and had processes in place to ensure all complaints were investigated and lessons learnt from the results were shared with all staff.**
- All staff we spoke with were aware of the complaints process and were encouraged where possible to try and resolve any complaints or concerns locally. Staff

were able to provide examples of where patients had verbally raised they were dissatisfied with something and staff had rectified it for them to prevent any formal complaints.

- The service had received no complaints between October 2017 and September 2018 (written or otherwise). However, the service had mistakenly sent a letter to a deceased patient as their electronic records had not been updated. Once the error was identified, staff quickly apologised to the family and offered an explanation as to how the error had occurred. Following this, staff from the service had completed a review and audit to ensure lessons were learnt and the error could not be repeated.
- We saw the complaints process on clear display and explanatory leaflets were openly available in the waiting room area. The staff we spoke with were aware of the complaints procedure and would provide patients with appropriate advice.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We previously did not have the authority to rate this service. However, on this inspection we did have authority to rate and we rated it as **requires improvement.**

Leadership

- **Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.**
- Staff spoke positively about the managers of the service and told us they were all visible and approachable. Managers led the team in a supportive and empowering manner, but were always available to provide assistance if required. Managers told us they had complete confidence in their staffs abilities to provide a professional service to patients.
- Staff told us succession planning had started to be factored into the service due to one key member of the team due to retire soon. Staff had been encouraged to complete training with new members of staff to ensure all staff were 'up-to-speed' by the time they left the service. Staff told us their managers had supported them through this process.
- Senior staff told us they also felt supported but also empowered to lead the service how they believe it should be lead. They understood the challenges to quality and sustainability and had the skills and abilities to address this.

Vision and strategy

- **The service did not have a defined vision or strategy for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.**
- Staff believed the main vision for the service was to ensure patients were provided with a high-quality service which was also provided in a timely manner.
- At the time of our inspection, all staff commented on the challenges which the service faced due to changes within the local acute hospitals. This had provided staff with an element of uncertainty over the future provision of scans at this location, and therefore made it difficult to devise a current strategy for the service.

Culture

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- The service was relatively small and all staff supported each other to provide the highest standard of care to the patients who underwent a scan. All staff respected each other and valued the contributions each member made to the service.
- All staff told us they were very much there for the patients and providing a service to the local community. This had always been their focus and would continue to be their focus until such a time that this service was no longer required. Staff told us the service had operated for 13 years and believed the success of the service had been the dedication to providing an experience which is patient focused.

- There were processes in place to manage staff who performed poorly or whose behaviour was not considered professional. Staff were unaware of any instances where staff had to be addressed using these processes.
- The service had an open and honest culture. Any incidents or complaints raised would have an open and honest 'no blame' approach to the investigation, however in circumstances where errors had been made, apologies would always be offered to the patients and staff would ensure steps were taken to rectify any errors. Staff were aware of the duty of candour regulation; however, they had not had any incidents which met the criteria where formal duty of candour had been required to be implemented.

Governance

- **The service did not always systematically improve service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.**
- The registered manager took the lead on clinical governance for the service, however all staff were involved in maintaining high quality care. Clinical governance meetings for all the clinical services at the University, including the DEXA scanning service were held on a bi-monthly basis. These meetings were minuted and the minutes provided for all staff to read and become familiar with. Staff also told us the head of diagnostic imaging regularly kept them informed of all relevant governance issues. However, during our inspection we found quality audits of the scan reports had not been undertake for 22 months and the governance systems in place had not identified this.
- Staff from the service were invited to participate in a radiation protection committee, along with the Radiation Protection Advisor (RPA). Minutes from these meetings showed there was oversight of the practices in all relevant areas and discussion around current legislation and guidance. For this service, there were no concerns identified and no reportable incidents raised, however it was acknowledged an operational policy was coming up for review. Staff told us, any pertinent or concerning points from these meetings were raised at the services own clinical governance meetings.
- However, during our inspection we found the local rules which staff were working from had not been updated to include the most recent version of the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017 and Ionising Radiation Regulations (IRR) 2017 and the governance systems in place had not identified this. Information received following our inspection showed a revised set of local rules were being drafted and were due to be reviewed at the next clinical governance meeting in March 2019.
- Staff working at the service were not required to provide their own indemnity insurance as they were all covered under the University's insurance.
- Staff at the service were not required to complete testing of backup generators, this would be completed by the engineers from the University. If staff from the service had any concerns, they would contact the engineers directly.

Managing risks, issues and performance

- **The service had systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- The service had a risk register in place to record any risks to the service. This was shared with the College of Health and Social Care and was regularly reviewed at clinical governance meetings. However, there appeared to be no risks evident on the risk register which was specifically related to the DEXA scanning service. Staff told us the DEXA scanning service was low risk in general, and therefore did not identify any clinical risks. Staff identified only one direct risk to the service which was the potential for the clinical commissioning group (CCG) to cease with the provision of the service from the University due to recent changes in the local acute hospitals. Although there had been no discussion or indication that this was being considered, it was a scenario which the senior managers had thought of, however this had not been recorded on the risk register at the time of the inspection.
- Staff at the service conducted risk assessments where appropriate. We saw examples of risk assessments for the management of the radiation risk within the location.

Good

Diagnostic imaging

- The most recent radiation protection audit which was conducted in August 2018 did not identify any risks which impacted on the care and treatment of patients. However, there were a number of actions for staff to complete, one of which was for the head of diagnostic imaging to identify other audits for DEXA specific services. Staff told us they were currently working through the action plan.
- The service did not use any formal methods for monitoring performance and were not required to provide the CCG with any formal data other than the number of DEXA scans completed per month. Staff regularly communicated with the managers about the scanning clinics they ran and would highlight any concerns or performance issues instantly. Any concerns or issues considered significant enough would then be escalated and raised during the bi-monthly clinical governance meetings.

Managing information

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- All staff were conscious of the requirements of managing a patient's personal information in accordance with relevant regulations and legislation. Staff told us when the new General Data Protection Regulations (GDPR) were released, they were required to complete additional training to ensure they were compliant with the regulations.

Engagement

- **The service demonstrated some engagement with patients, to plan and manage appropriate services.**
- The service had patient comment boxes available in the waiting room to collect the satisfaction cards in. These results were then analysed regularly and a report was completed for staff to review. Information from March 2018 and July 2018 showed all patients who completed a feedback form would recommend the service to their friends and family.
- There was evidence of staff from the service implementing changes when patients had feedback concerns through the satisfaction cards. The report from July 2018 showed there were concerns about the signage for patient to follow to the scanning suite. Staff from the service have since amended and updated the signage so all patients were able to easily get to the scanning suite.

Learning, continuous improvement and innovation

- **The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation. However at the time of our inspection, there was little evidence of where this had taken place within the service.**
- Staff told us as they had only been registered with the CQC for a short time, their focus had been on ensuring a quality service was maintained. This included ensuring all policies, processes and training was up-to-date and any areas for improvement identified through on-going audits and patient satisfaction cards, actioned. However, during our inspection, we found the examples of where the service was not always adhering to their intended improvement process with policies referencing out of date regulations and quality audits not conducted for a significant period of time.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure staff have access to required policies to enable them to provide high quality, safe care and treatment. And, that all policies, procedures and guidance include the most up-to-date regulations, legislation and best practice.
- The provider must ensure there is a robust governance process in place to ensure the quality of the scan reports produced by the service.
- The provider must ensure all risks to the service are identified, assessed and managed.
- The provider must ensure they have adequate oversight of mandatory training completed by staff.

Action the provider SHOULD take to improve

- The service should continue to look for additional audits they can undertake to collect data on patient outcomes.
- The provider should continue to monitor their did not attend rates.
- The provider should consider how they can improve their patient feedback rates.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met** • There was a lack of oversight of staff mandatory training. • Governance systems were not robust enough to identify outdated regulations were referenced in the local rules and that no quality control audits had been completed in 22 months. • Lack of Infection Prevention and Control policy in place to provide correct guidance for staff to follow within the clinical environment. • Lack of awareness of the risk when having relatives translate and interpret for patients who do not have English as their first language. Regulation 17 (1) (2) (a) (b)