Ecospirito Ltd

# Fastrack Scan

**Inspection report**

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

## Ratings

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

# Summary of findings

## Overall summary

We inspected Fastrack Scan because at our last inspection, we rated the location as inadequate and placed the provider in special measures to help it improve.

Our rating of this service went down. We rated it as inadequate overall as we rated safe, responsive and well-led as inadequate. We do not rate the effectiveness of diagnostic imaging services and we did not inspect caring as part of this inspection.

During our inspection we found:

- The service did not have staff with the necessary skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Not all staff had completed mandatory training, which included basic life support. Not all staff had undertaken safeguarding training appropriate to their role.
- The design, maintenance and use of facilities did not always keep people safe, as not all equipment had been serviced and staff did not manage clinical waste well. The service did not always use effective control measures to protect patients, staff and others from infection.
- The service did not manage patient safety incidents well. There was no clear process for reporting, managing or investigating incidents, or for the sharing of lessons learnt with the team. Managers did not ensure that actions from patient safety alerts were implemented or monitored.
- The service did not always provide care and treatment that was based on national guidance or evidence-based practice. There were no processes in place to ensure staff followed up-to-date guidance. Staff did not monitor the effectiveness of care and treatment, and therefore could not use the findings to make improvements and achieve good outcomes for patients.
- The service did not make sure all staff were competent for their roles. Managers did not appraise staff's work performance and did not hold supervision meetings with them to provide support and development.
- It was not easy for people to give feedback and raise concerns about the care received. There were no robust processes in place for investigating complaints and sharing lessons learnt.
- Leaders did not have the skills and abilities to run the service. They did not understand or manage the priorities and issues the service faced. Leaders did not operate effective governance processes, either throughout the service or with partner organisations. Staff were not clear about their roles and accountabilities, due to a lack of robust governance and oversight procedures. Staff did not have regular opportunities to meet, discuss and learn from the performance of the service.
- The service did not have a vision or strategy for what it wanted to achieve.
- Leaders and teams did not use systems to identify and manage risks to patients and the service. They did not identify or escalate relevant risks and issues, nor identify actions to reduce their impact.
- The service did not collect reliable data and analyse it to understand performance, make decisions and drive improvements. Personal information was not processed in line with data protection guidelines.
- Leaders and staff did not engage with patients, staff, equality groups or the public to plan and manage services.
- Staff were not always committed to continually learning and improving services. They did not have a good understanding of quality improvement methods and the skills to use them.

However:

- Key services were available seven days a week to support timely patient care. The service planned care to meet the needs of local people and the communities served, and people could access the service when they needed it.

# Summary of findings

- Staff followed guidance to gain patients' consent prior to undertaking any scan. Staff ensured patients understood the radiation risks associated with the scan.

Following our inspection, we took enforcement action against the provider due to continued non-compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which included Regulations 12, 13, 17 and 18. This enforcement action included the cancellation of the provider's registration and the registered manager's registration with CQC, which resulted in the provider no longer being registered to undertake their regulated activities, diagnostic and screening procedures.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Diagnostic imaging** | Inadequate  | Our rating of this service went down. We rated it as inadequate overall as we rated safe, responsive and well-led as inadequate. We do not rate the effectiveness of diagnostic imaging services and we did not inspect caring as part of this inspection. |

# Summary of findings

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# Summary of this inspection

## Background to Fastrack Scan

Fastrack Scan is operated by Ecospirito Ltd and provides a dual energy x-ray absorptiometry (DEXA) scanning service from a mobile unit. The majority of patients are referred from an independent hospital group based in the East of England, but the service also sees self-funded patients and private clients.

At the time of our inspection, the service had a registered manager in post, who had been in position since their initial registration with CQC in May 2018, and was registered to undertake the following regulated activities:

- Diagnostic and Screening Procedures

We last undertook a comprehensive inspection of this service on 2 April 2019. Following this, we rated the location as inadequate overall. As the service was not meeting the legal requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we issued the provider with two requirement notices relating to breaches of Regulations 11 and 17. Following this inspection, we made the decision to suspend the service for a period of eight weeks, due to concerns patients may be exposed to risk of harm. We also took action to place the provider into special measures.

We undertook a focused inspection on 29 May 2019 to follow up these concerns. Whilst the service had made some improvements, there was continued non-compliance in a number of areas, including significant concerns with governance. The service remained rated as inadequate and stayed in special measures. Following this inspection, we told the provider they must take actions to improve and issued a warning notice in relation to governance.

To check whether the service had addressed these concerns, we conducted a short-notice announced inspection on 6 November 2020, which we followed with interviews with both the registered manager and the radiation protection supervisor on 13 November 2020. These interviews were conducted remotely due to the ongoing COVID-19 pandemic at the time of our inspection. Following this inspection, we found that the provider was still non-compliant in some of the areas previously identified. The significant improvements required had not been made and the provider remains rated as inadequate. The regulatory action section at the end of this report details the legal requirements the provider did not meet.

## How we carried out this inspection

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

## Areas for improvement

Action the provider MUST take is necessary to comply with its legal obligations. Action a provider SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

**Action the provider MUST take to improve:**

# Summary of this inspection

We told the provider that it must take action to bring services into line with legal requirements. This action related to diagnostic services.

- The provider must ensure it has systems and processes in place to adequately identify, assess and mitigate all risks affecting patients (Regulation 12(1)).
- The provider must ensure has a robust overview of all risks affecting patients, including environmental risk assessments (Regulation 12(1)).
- The provider must ensure it operates a planned equipment maintenance programme (Regulation 12(1)).
- The provider must ensure it provides clinical waste bins for the disposal of infectious or contaminated waste. This must include procedures for the disposal and collection of any clinical waste (Regulation 12(1)).
- The provider must ensure staff follow correct hand hygiene procedures to minimise the risk of the spread of infections (Regulation 12(1)).
- The provider must ensure all equipment and devices, such as the window blinds, are compliant to relevant infection prevention and control standards and do not pose an environmental hazard (Regulation 12(1)).
- The provider must ensure all staff receive appropriate basic life support training (Regulation 12(1)).
- The provider must ensure infection prevention and control measures put in place to prevent and control the spread of coronavirus are effective (Regulation 12(1)).
- The provider must ensure it has established systems and processes that it operates effectively to prevent abuse of service users (Regulation 13(1)(2)).
- The provider must ensure all staff receive safeguarding training that is to an appropriate standard for their role (Regulation 13(1)(2)).
- The provider must ensure they have a chaperone policy and formal processes in place for if a patient requires a chaperone. This must include processes to provide safe care for any child, young person, carer or other persons accompanying the patient for their scan (Regulation 13(1)(2)).
- The provider must ensure they have a robust complaints reporting and investigation process (Regulation 17(1)).
- The provider must operate effective systems and processes that ensure risks to service users are recorded and monitored effectively (Regulation 17(1)).
- The provider must ensure all policies are clear, robust and of good quality (Regulation 17(1)).
- The provider must ensure policies refer to external guidance where appropriate (Regulation 17(1)).
- The provider must ensure there is a systematic process to continually review, revise and update policies, as appropriate. The provider must ensure any amendments are clearly detailed and communicated to staff (Regulation 17(1)).
- The provider must ensure they maintain a robust set of policies and procedures that are relevant for their service, up-to-date, and not in contradiction with other policies. The provider must ensure all policies refer to correct staff roles, and clearly detail each person's specific roles and responsibility under each policy (Regulation 17(1)).
- The provider must ensure key staff documents, such as the staff handbook, are fully completed and contain correct information (Regulation 17(1)).
- The provider must ensure all confidential and patient identifiable information is appropriately and securely stored (Regulation 17(1)).
- The provider must ensure an information retention schedule is in place. The provider must ensure staff are aware of how long information should be retained for. The provider must ensure processes are in place to delete information once it should no longer legally hold it, in line with the General Data Protection Regulation (Regulation 17(1)).
- The provider must ensure they operate a robust incident reporting and investigation process (Regulation 17(1)).
- The provider must ensure they operate a clinical audit process to review and audit scan imagery and image reports (Regulation 17(1)).
- The provider must ensure they have processes in place to monitor or audit the use of the service's exclusion criteria (Regulation 17(1)).

# Summary of this inspection

- The provider must ensure all video recording capable devices are appropriately signed to patients. The provider must ensure the use of these devices is supported with appropriate policies, procedures and risk assessments, and usage of these devices is in line with appropriate data protection legislation (Regulation 17(1)).
- The provider must ensure all staff receive a regular appraisal (Regulation 18(2)).
- The provider must ensure they operate effective processes to ensure staff receive mandatory and statutory training (Regulation 18(2)).
- The provider must ensure they develop a mandatory training programme that is based on the needs and requirements of each staff role and have robust systems in place to monitor completion compliance (Regulation 18(2)).
- The provider must ensure they operate robust competency assessment processes to ensure all staff remain competent to use all required equipment (Regulation 18(2)).
- The provider must ensure they display their CQC rating on their website (Regulation 20A(1)).

**Action the provider SHOULD take to improve:**

We told the provider that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

- The provider should consider replacing the carpet wall coverings in the scanning vehicle with a surface that allows for effective cleaning and decontamination.
- The provider should consider subscribing to patient safety alerts, including, but not exclusive to, the Medicines and Healthcare products Regulatory Agency (MHRA) patient safety alerts to allow patient safety alerts to be monitored and implemented promptly.

# Our findings

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| **Diagnostic imaging** | Inadequate | Inspected but not rated | Not inspected | Inadequate | Inadequate | Inadequate |
| **Overall** | Inadequate | Inspected but not rated | Not inspected | Inadequate | Inadequate | Inadequate |

Inadequate

# Diagnostic imaging

| | |
|---|---|
| Safe | Inadequate |
| Effective | Inspected but not rated |
| Responsive | Inadequate |
| Well-led | Inadequate |

## Are Diagnostic imaging safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate because:

- Not all staff had completed mandatory training, which included basic life support. There was not a robust mandatory training programme in place that was based on the needs and requirements of each staff role. The provider did not have a robust process to monitor completion of courses, and there was no policy in place that stated when training required refreshing.
- Not all staff had undertaken safeguarding training to appropriate levels. The service employed two members of staff who both conducted patient scans. According to the intercollegiate document, *Adult Safeguarding: Roles and Competencies for Health Care Staff* (published August 2018), "all practitioners who have regular contact with patients, their families or carers, or the public" are required to undertake level 2 training. We did not see evidence all staff had achieved this level of training. The service did not employ any staff who had undertaken level 3 adult safeguarding training or higher and they did not have any formal arrangements in place with other organisations for obtaining advice from staff who had undertaken this training.
- The service did not always use effective control measures to protect patients, staff and others from infection. The vehicle interior consisted of vinyl flooring and carpeted walls. This was not in line with the *Health Building Note 00-09* guidance from the Department of Health, published March 2013, which states "carpets should not be used in clinical areas". As a temporary measure during the COVID-19 pandemic, the provider had installed plastic sheeting over the carpeted walls, which were affixed to the ceiling and flooring with a metallic sticky tape. We saw several areas where this tape had pulled away and saw air gaps in the plastic sheeting. We were not assured this provided effective mitigation to prevent the spread of COVID-19. We were not assured staff followed best hand hygiene practices, as staff washed their hands by filling a sink bowl with hot and cold water. This was not in line the *Five Moments for Hand Hygiene* guidance published by World Health Organisation, which states hands should be rinsed with water from a tap. The provider had two Venetian blinds in the scanning room that contained a fabric pull cord, which trailed close to the floor. This was not in line with the *Health Building Note 00-09* guidance from the Department of Health, published March 2013, which states that "window blinds that are not readily amenable to cleaning are not recommended". We were also concerned the trailing cord could pose an environmental hazard. However, we did note premises and equipment appeared visibly clean.
- The design, maintenance and use of facilities did not always keep people safe, as not all equipment had been serviced. Several items of equipment had exceeded recommended service schedules. We saw the vehicle tail-lift was

due for service on 9 September 2020 and did not see evidence of this being undertaken. The provider attributed this due to the service not operating during the coronavirus pandemic; although, we saw the provider reopened the service from September 2020 and saw no plans in place for these to be addressed. However, we did note the scanner had been serviced in September 2020.

- For overnight security, the provider had installed a video doorbell inside the lorry, which was positioned to look down the length of the vehicle. Although the provider told us they did not use this during the day when patients attended the unit, the provider told us they could access the device at any time using a mobile phone. We did not see any patient signage informing them of the presence of video recording devices, and did not see any policies, procedures or risk assessments for the use of this technology.
- Staff did not manage clinical waste well. The provider did not have any clinical waste bins or procedures for the disposal of clinical waste. During our inspection, staff explained they disposed of any clinical waste in the vehicle household waste bin, which staff told us they would dispose of at their home address or via a hospital site. This was not in line with the *Health Technical Memorandum 07-01: Safe Management of Healthcare Waste* guidance from the Department of Health, published 2013, which states "container labels should clearly identify the waste type(s) present within" and that this type of clinical waste from healthcare environments must be disposed of through incineration or treatment at a licensed centre.
- Not all environmental risks had been identified or mitigated. For example, entry into the vehicle was via three large steps, which converted into a wheelchair accessible lift. There was no accompanying environmental risk assessment for use of this and we were not assured the risks associated with this had been effectively identified, assessed or mitigated. Following our inspection, the provider sent us a copy of a further risk assessment that detailed 12 hazards that affected the service, including the wheelchair lift. However, we saw this document was dated 'May' but did not include a year. There was no evidence of regular review of this document. We saw several actions required further actions to control or mitigate the risk, however there was not always clear details of who owned each risk and of when action should be taken by.
- We saw the service had considered the risks associated with radiation. We saw the provider had installed patient information signs in the scanning area to alert patients to the risks of radiation, including signs to advise patients to inform staff if they were pregnant. Staff had access to the provider's local rules. This is a collection of documents that detail procedure that staff must follow to ensure any exposure of radiation is in line with the Ionising Radiation (Medical Exposure) Regulations 2017. Staff signed the radiation protection file to confirm they had read and understood these. Staff wore individual radiation dosimeters to monitor the level of any radiation they may have been exposed to. During our inspection, we reviewed the last dosimetry report from May 2020 that detailed no staff member had been exposed to any radiation. Patients were required to complete a patient history questionnaire and consent form that highlighted any potential areas of risk, prior to any scan being undertaken. This included previous medical history, such as a diagnosis of arthritis or osteoporosis, as well as lifestyle factors, such as any smoking or alcohol consumption.
- The service did not have staff with the necessary skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. At the time of our inspection, the service employed two members of staff. Staff told us they were both present during every scanning session, and they would not undertake a session if only one of them could be present. The service reported no staff vacancies at the time of our inspection and were in the early stages of recruiting a new member of staff. However, we did not see evidence all staff had undertaken formal training or assessment on using all specialist equipment, including the scanner. We did not see a formal induction process in place. This was not in line with the service's staff handbook, which stated staff would receive an induction programme based on the scope and complexity of their role, complemented by induction checklists and evaluation sheets. We reviewed the radiation protection file and saw a document entitled 'in-house and annual training scheme contingency arrangements', which detailed the training procedures staff should undertake. We saw this included the reading of 'appropriate information', reading the unit's local rules and receiving training to use the equipment by a

'designated trainer'. We saw the service had listed both the registered manager and the radiation protection supervisor as designated trainers but saw no evidence that either party had undertaken any specific trainer training or mentoring. However, we did note both members of staff had completed a radiation protection supervisors course for x-ray users in 2019.

- The service did not store all records of patients' care securely. During our inspection, staff explained the majority of patient records and scan results were electronic and were stored on a series of encrypted hard drives, which they stored securely and separately from the vehicle. Staff explained any paper records were stored in a locked cabinet within the vehicle. However, during our inspection, we found five pages of confidential patient information that was stored in a cupboard that could not be secured. This included copies of patient names, dates of birth, heights, weights, GP details and reasons for referral.
- The provider did not prescribe, administer, record or store medicines as part of their service.
- The service did not manage patient safety incidents well. There was no clear process for reporting, managing or investigating incidents, or for the sharing of lessons learnt with the team. Managers did not ensure that actions from patient safety alerts were implemented or monitored. The provider recorded all incidents in a hand-written notepad, entitled 'significant events'. The provider did not have a policy for the reporting or investigation of incidents. We reviewed a policy from May 2018 on 'accident reporting' and saw this did not set out a clear process for staff to report accidents. The policy did not detail any staff roles or detail any individual responsibilities. The policy was due to be reviewed every two years, but the policy had not been reviewed. We did not see any evidence either member of staff had undergone any incident investigation or root cause analysis training. The provider did not subscribe to any patient safety alerts, such as the Medicines and Healthcare products Regulatory Agency (MHRA) alerts. The registered manager told us they had a good relationship with the scanner manufacturer and would be informed if there were any recalls or alerts. However, we were not assured this was a robust process, as this did not include any other items of equipment used.
- The service did not monitor results to improve safety. The service did not have any robust procedures or processes in place to share learnings with other providers, or to monitor the performance of the service to improve safety for patients.

## Are Diagnostic imaging effective?

Inspected but not rated

We do not rate effective for this type of service.

- The service did not always provide care and treatment that was based on national guidance or evidence-based practice. There were no processes in place to ensure staff followed up-to-date guidance. Although the service had several policies and guidance documents in place, the majority of these did not reference or comply with national or external guidance. For example, we reviewed the policy for cardiopulmonary resuscitation (CPR) during our inspection and saw this did not reference any guidance, including any from the Resuscitation Council UK. One section of the policy stated that the defibrillator will "probably be handled by a hospital staff member" and that "the 150 Joule shock is generally effective". We reviewed the first aid policy, which stated staff should call "911" if they needed support and were not at a hospital site, rather than '999' for emergency services in the UK. We saw it stated, "should bleeding be pulsatile, a tourniquet might be needed", but did not specify staff should be appropriately trained in the use of tourniquets. However, we did note the provider had local rules in place in the radiation protection folder that referred to the Ionising Radiations Regulations (IRR) 2017 and Ionising Radiation (Medical Exposure) Regulations 2017.
- Staff could provide patients with bottled water, if patients requested this. Due to the nature of the service, staff did not routinely provide food for patients. However, in the event of a medical emergency, staff could provide patients with high sugar foods and snacks.

Inadequate

# Diagnostic imaging

- Due to the nature of the service, the provider did not provide pain relief.
- Staff did not monitor the effectiveness of care and treatment, and therefore could not use the findings to make improvements and achieve good outcomes for patients. The provider did not collect or monitor information regarding patient outcomes. There was no formal clinical audit process in place to assess, monitor or improve the quality and safety of the service. The provider did not undertake any audit or review of the quality of scan images to determine their quality, or the competence of the member of staff conducting the scan. This was not in line with *The Role of the Radiographer in DXA and Osteoporosis Services* guidance published by The Society and College of Radiographers, published August 2018, which states "radiographers must undertake continuing professional development and perform quality assurance and clinical audit".
- The service did not make sure all staff were competent for their roles. Managers did not appraise staff's work performance and did not hold supervision meetings with them to provide support and development. There was no process in place to ensure staff received regular ongoing supervision to confirm they remained competent for their roles. The registered manager received an appraisal from an independent healthcare provider in 2019, but the radiation protection supervisor had not received an appraisal. We reviewed a 'summary training register' in the radiation protection file, which provided a record of all completed training and continuing professional development (CPD). We saw only the radiation protection supervisor had completed this, and there was only one entry under the supplementary training and CPD column, which detailed the attendance of a cardiopulmonary resuscitation course in 2020. However, we did note both the registered manager and the radiation protection supervisor had completed a radiation protection supervisors' course in 2019.
- Due to the small size of the service, there were limited opportunities for staff to work with other healthcare professionals. The provider employed two staff; a radiologist and a radiation protection supervisor. The majority of the service's activity came through a service level agreement with a group of independent hospitals. Staff reported a good working relationship with the hospital group and described how they worked with referring clinicians.
- Key services were available seven days a week to support timely patient care. As the service's main activity was to provide a mobile scanning service to a group of independent hospitals, the provider worked to ensure they met the needs of the hospital group. The service worked to ensure they could provide sessions when required, including short-notice and recurring sessions, both during week days and at weekends.
- Due to the nature of the service, the provider did not provide health promotion advice.
- Although staff had undertaken training in the Mental Capacity Act 2005, we were not assured all staff understood their roles and responsibilities under this, as we saw the provider's policy did not detail any individual staff roles or responsibilities or provide any contact details or routes for escalation if staff had any concerns. However, we saw staff followed guidance to gain patients' consent and ensured patients understood the radiation risks prior to undertaking any scan. We saw staff achieved this through the completion of a patient history questionnaire, which they required all patients to complete prior to their scan.

## Are Diagnostic imaging responsive?

Inadequate

Our rating of responsive went down. We rated it as inadequate because:

- The service planned care to meet the needs of local people and the communities served. As the scanning unit was located in a converted lorry, it travelled to hospital and community locations as required. The provider relied on signage, car parking and toilet facilities of the host location; however, the lorry was clearly labelled and branded from

the outside to indicate its function. The provider did not scan any children or young people. As the provider only scanned one patient at a time, and patients only entered the lorry for their allocated appointment, the scanning unit provided a naturally quiet area for patients. We did not see any dedicated support available for patients with mental health conditions, learning disabilities, autism or dementia.

- The service did not always take account of patients' individual needs. Although the service provided patients with information leaflets regarding their scan, these were not available in large print, accessible formats or in other languages. The service did not have a chaperone policy or have formal processes for obtaining a chaperone if a patient required this. Staff told us they could seek support from the independent hospital group, including to care for any children who may have accompanied the patient to the scan, but we saw no formal agreement or process in place for this. The service operated exclusion criteria that detailed patient groups they could not scan, but we did not see any audit or monitoring processes regarding the use of this. However, we did note the provider had access to a telephone translation service for patients who did not speak English.
- People could access the service when they needed it. The majority of scans undertaken by the provider were during pre-booked sessions for an independent hospital group. The provider told us they worked hard to meet the needs of these hospitals and often undertook scanning sessions during weekends. Although the provider usually requested a few days' notice, they told us they would work to fulfil any short-notice request by the hospital, including over weekends.
- It was not easy for people to give feedback and raise concerns about the care received. There were no robust processes in place for investigating complaints and sharing lessons learnt. The service did not have a complaints process in place for the reporting and investigating of patient complaints. During our inspection, we did not see any information in patient-facing areas on how patients could raise a complaint. We reviewed copies of patient information literature that all patients received before and after their scan and saw this did not contain any details on how to raise a complaint. However, we did note the provider did display a CQC 'tell us about your experience of care' poster.

## Are Diagnostic imaging well-led?

Inadequate

Our rating of well-led stayed the same. We rated it as inadequate because:

- Leaders did not have the skills and abilities to run the service. They did not understand or manage the priorities and issues the service faced. Although they were visible and approachable in the service for patients and staff, they did not support staff to develop their skills or to take on more senior roles. The service was led by a registered manager who was a radiologist. The provider also employed a radiation protection supervisor, who acted as the scan operator. Whilst the registered manager had the skills and experience to undertake dual-energy x-ray absorptiometry (DEXA) scans, we were not assured they had the skills or experience to run a safe service or the abilities to implement the required improvement. We last inspected this service in April 2019 and again in May 2019, following which several concerns were raised with the provider. During our most recent inspection, we saw the majority of these concerns remained unresolved as the provider had taken little action to address these. We were therefore not assured the registered manager understood or had the capability to manage the risks the service faced.
- The service did not have a vision or strategy for what it wanted to achieve. Although one member of staff told us the future goal was to expand the service with an additional lorry, we did not see this documented anywhere.
- Staff felt respected, support and valued. Although there was an open culture where staff could raise concerns without fear, there was not a focus on safety, quality and the needs of patients. Staff told us they felt supported by the registered manager and the service and would have no concerns raising any issues with them. We saw there was an open and collaborative culture between all members of staff. However, we saw the culture was not focused on patient safety.

Inadequate

# Diagnostic imaging

- Leaders did not operate effective governance processes, either throughout the service or with partner organisations. Staff were not clear about their roles and accountabilities, due to a lack of robust governance and oversight procedures. Policies were of poor quality. Policies lacked key information, including details of authorship, creation dates, review dates or periods, version history, and titles. We saw multiple versions of some policies, including the adult safeguarding policy. Policies lacked any reference to external guidance or best practice. We saw some policies included instructions for staff that could put patients at risk, due to detailing instructions or referencing equipment that the provider did not have, or that staff were not trained to use. Other policies mentioned roles that were not designated roles within the service. For example, the health and safety policy referred to a 'chief executive', 'directors', 'senior managers', a 'safety officer' and a 'fire officer'. We saw there was not a systematic process in place to continually review, revise and update policies. We saw the registered manager made amendments to several policies by hand and had signed and/or dated each policy; however, it was unclear whether this date referred to its creation date or a review date. There was no process in place to confirm staff had read and understood each policy. Policies rarely referred to specific job roles and lacked detail as to individual roles and responsibilities. Not all safety checks were documented when completed. We saw staff completed a safety log once they cleaned or tested certain items, such as the smoke alarm or generator, but this log did not cover all items that required checking. For example, in the health and safety policy, it stated staff should check battery and lighting points every six months and electric points every year. However, staff did not record when they completed these checks and when they were next required.
- Staff did not have regular opportunities to meet, discuss and learn from the performance of the service. Although we saw the registered manager had received an appraisal from an independent hospital, we saw no systems in place to ensure other staff received a regular appraisal of their work performance. We could therefore not be assured that all staff were effectively supported in their development.
- Leaders and teams did not use systems to identify and manage risks to patients and the service. They did not identify or escalate relevant risks and issues, nor identify actions to reduce their impact. The provider did not have a risk register. Prior to our inspection, we requested this but were sent a copy of an 'office risk assessment' that dated from May 2013. This detailed eight generic risks that could affect the service but was not tailored or at times relevant for the service. For example, it included a risk associated to gas appliances, even though the service did not have any gas appliances. We did not see any additional risk assessments or registers in place to address other risks which affected the service, such as the impact of coronavirus, or the service's non-compliance to the Health and Social Care Act regulations.
- The service did not collect reliable data and analyse it to understand performance, make decisions and improvements. Although electronic information systems were secure and the service had appointed a data protection officer with the Information Commissioner's Office, personal information was not processed in line with data protection guidelines. For example, the service did not operate an information retention schedule. During our inspection, we discussed information retention with staff, but staff were unaware of how long information should be retained for. There was no process for deletion of personal information when it was no longer required by the service. At the time of our inspection, the provider was failing to display their CQC rating on their website, which was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Leaders and staff did not engage with patients, staff, equality groups or the public to plan and manage services. Although the service conducted a patient satisfaction survey, it was unclear how often these were issued or returned as they did not include a date. We did not see any evidence the provider collated, assessed or discussed this feedback with the team, nor implemented any changes as a result of patient feedback. However, we did note the provider worked with an independent hospital group to deliver their service.
- Staff were not always committed to continually learning and improving services. They did not have a good understanding of quality improvement methods and the skills to use them. The provider did not have systems or processes in place to undertake any continuous improvement, quality improvement or innovation. However, we noted the provider had undertaken scanning sessions as part of wider research projects, including an external three-year project investigating sarcopenia (a skeletal muscle disorder) and physical frailty in older people.

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<br>• The provider did not have systems and processes in place to adequately identify, assess and mitigate all risks affecting service users.<br>• The provider did not operate a planned equipment maintenance programme.<br>• The provider did not have effective processes in place to safely manage the disposal of clinical or infectious waste.<br>• The provider did not have appropriate systems and equipment in place to support effective hand hygiene.<br>• The provider did not take all appropriate steps to minimise the potential spread of infection within the scanning unit.<br>• Not all staff had received appropriate basic life support training.<br>• The provider's policies and procedures lacked reference to external guidelines, such as their policies on cardiopulmonary resuscitation and first aid. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures | Regulation 20A HSCA (RA) Regulations 2014 Requirement as to display of performance assessments<br>• The provider failed to display their CQC rating in an appropriate place on their public website. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures | Regulation 17 HSCA (RA) Regulations 2014 Good governance |

This section is primarily information for the provider

# Enforcement actions

- The provider did not have established systems and processes in place to effectively assess, monitor and improve the quality and safety of services.
- The provider did not effectively operate systems to assess, monitor and mitigate risks.
- The provider did not have robust policies and procedures in place. We found instances where policies were missing version numbers, author details, creation and review dates. We saw the provider operated multiple versions of the same policy, with information duplicated across several different policies.
- The provider did not keep key staff employment information, such as their staff handbook, accurate and up-to-date.
- The provider did not take appropriate measures to ensure confidential patient information was stored securely.
- The provider did not have an information retention schedule in place.
- The provider did not have a robust incident and complaints reporting, investigation and learning process in place.
- The provider did not have a clinical audit process in place for the auditing of scan imagery and reports.
- The provider did not have a process in place to monitor or audit the use of their exclusion criteria.
- The provider did not have appropriate patient-facing signage or appropriate risk policies, procedures and risk assessments in place for the use of a video recording device located in the scanning lorry.
- The provider did not operate a definitive list of mandatory training courses that all staff were required to complete.

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br>• The provider did not have established systems and processes in place to prevent abuse.<br>• Not all patient-facing staff had completed safeguarding training to a minimum of level 2 standard. |

This section is primarily information for the provider

# Enforcement actions

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>• The provider did not appraise staff performance or have a robust system in place to assess and re-assess each staff members' competency with all equipment.<br>• The provider did not have effective processes in place to ensure staff received all required mandatory training. |