

University of Wolverhampton

Quality Report

Walsall Campus,
Gorway Rd,
Walsall
WS1 3BD
Tel: 01902 321120
Website: www.wlv.ac.uk/healthscan

Date of inspection visit: 20 November 2019
Date of publication: 14/01/2020

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Healthscan is operated by University of Wolverhampton. The service is based within the University of Wolverhampton facilities on the Walsall campus.

Facilities include one dual-energy X-ray absorptiometry (Dexa) scanning unit which is used for diagnostic imaging. There is a reception, waiting area and two staff offices.

The service provides diagnostic imaging to adults over the age of 18 years of age.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection (staff did not know we were coming) on 20 November 2019.

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

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

Services we rate

We have not previously rated this service and cannot therefore compare ratings with the last inspection. We rated it as **Requires improvement** overall.

We rated it as Requires improvement because:

- Staff did not receive training in the Mental Capacity Act 2005 meaning they may not always be able to recognise, and respond appropriately to, patients who were unable to provide consent to treatment.
- Complaints information was not clearly displayed. This meant that patients may not easily be able to make a complaint as details of the process were not widely available.
- Governance around the service contract and performance was not in place as there was no formal contract agreement, agreed key performance indicators, or contract meetings.
- There was minimal audit happening in the service which gave no assurance for performance or outcomes and no means of identifying any areas for service improvement.
- The service did not routinely document patient's consent to receiving a scan. Assurance in effective consent processes could not be provided.

However, we found the following areas of good practice:

- We found that the clinical environment was appropriate for the service delivered and was visibly clean. Infection prevention control processes were followed by staff.
- There was good compliance with IR(ME)R 2017 regulations and there were effective local rules to ensure radiation was managed safely.
- The service's policies and procedures were based on national guidance and evidence-based practice was being delivered.
- The service was able to be responsive to referrals and reported they offered appointments with minimal waits for patients.
- We saw that staff displayed a caring approach and patients provided positive feedback about the service.

Summary of findings

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

Heidi Smoult

Deputy Chief Inspector of Hospitals (Midlands region)

Summary of findings

Our judgements about each of the main services

Service

Rating

Summary of each main service

Diagnostic imaging

Requires improvement



- Staff did not routinely document patient consent and did not receive Mental Capacity Act training. The service was therefore unable to demonstrate they had appropriate conversations about consent to a scan when patients may not have capacity to make decisions.
- It was not always easy for people to give feedback and raise concerns about care received as complaints information was not clearly displayed.
- Staff provided good care and treatment but did not monitor the effectiveness of the service. Staff did not routinely complete audits and therefore could not use this information to improve the service.
- The service could not demonstrate that they provided care in a way that met the needs of local people. Although staff told us that patients could access the service when they needed it and received the right care promptly, they could not provide evidence to support this.
- The service did not routinely collect performance information in order to be able to monitor and improve services.

However:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed

Summary of findings

safety well. The service generally controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records.

- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.
-

Summary of findings

Contents

Summary of this inspection

Background to University of Wolverhampton	Page 8
Our inspection team	8
Information about University of Wolverhampton	8

Detailed findings from this inspection

Overview of ratings	10
Outstanding practice	29
Areas for improvement	29
Action we have told the provider to take	30

Requires improvement 

Services we looked at

Diagnostic imaging

Summary of this inspection

Background to University of Wolverhampton

Healthscan is operated by the University of Wolverhampton. The service opened in February 2019. It is a diagnostic imaging service based on the Walsall campus of the University of Wolverhampton. The service accepts referrals from consultants based at Walsall Manor Hospital only.

The service has had a registered manager in post since February 2019. However, at the time of the inspection, a new registered manager was in the process of being appointed.

We inspected this service on 20 November 2019 using our comprehensive inspection methodology. The inspection was unannounced (staff did not know we were coming).

The facility is based within the William Penny Brookes building at the University of Wolverhampton. It is located on the first floor and is accessed by stairs or a lift. The service has one dual energy x-ray absorptiometry (DEXA) scanner unit and offers appointments Monday to Friday from 9am to 3.30pm. A DEXA scan uses low dose x-rays to

take measurements to work out the strength (density) of patient's bones. The facility includes a designated waiting area and reception, the scan room, two staff offices and a cleaning cupboard.

There is an arrangement in place for the service to offer DEXA scans or bone densitometry scans to adults over the age of 18. However, there was no formal written service level agreement with the local NHS trust who referred patients for DEXA scans.

There are two designated parking spaces close to the building, reserved for patients attending for scan appointments.

The service consists of one senior radiographer and a registered manager who is a nurse.

Arrangements for emergency patient care i.e. in the event of cardiac arrest, are via a 999 call to the paramedic ambulance service. Staff have basic life support training and there is first aid equipment in the clinic and a defibrillator is available within the building.

Our inspection team

The team that inspected the service comprised a CQC lead inspector on site, who was supported by an inspection manager who was off site. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

Information about University of Wolverhampton

The service provided dual energy x-ray absorptiometry scans. This location is registered to provide the following regulated activity:

- Diagnostic and screening procedures.

During the inspection, we visited the scanning room at the Walsall campus site of the University of Wolverhampton. We spoke with two staff; the registered manager, and the senior radiographer. We spoke with two

patients and observed two episodes of patient care delivery. During our inspection, we reviewed two sets of patient records. We reviewed policies, training records and audit results.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the eight months that the service had been operating for before this inspection. We have not previously inspected this location.

Summary of this inspection

During this inspection we identified breaches of regulation 17 and regulation 11.

Activity (February 2019 to October 2019):

The service had an expected annual volume of scan delivery for up to 700 patients. From February to October 2019 the service had performed 669 scans. All patients seen were NHS-funded.

Track record on safety (February 2019 to October 2019):

- No never events or serious injuries

- No IR(ME)R reportable incidents
- One incident was reported from February 2019 to October 2019, which was not patient related
- No complaints had been reported since the service had been in operation.

The premises used by the service were owned by the University of Wolverhampton who had responsibility for all building and equipment maintenance and cleaning services. Staff working in the service were employed by the University of Wolverhampton.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

Diagnostic imaging

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

Are diagnostic imaging services safe?

Good 

We have not previously rated this service and cannot therefore compare ratings with the last inspection. We rated it as **good**.

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. We saw that the senior radiographer and the registered manager were both up to date with all their mandatory training requirements. All training modules were provided through the University of Wolverhampton.

The mandatory training was comprehensive and met the needs of patients and staff. There were some training sessions that were required to be completed two-yearly, some that needed to be completed every three years and some that were a once only requirement. Training topics included data protection, fire safety, infection prevention control, first aid, basic life support, manual handling and dementia awareness. Training was mostly completed online except for manual handling, basic life support and first aid training which were delivered face to face.

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.

Staff received training specific for their role on how to recognise and report abuse. The senior radiographer had completed safeguarding level two training for both adults and children. The registered manager was trained to level three in safeguarding adults and to level two for safeguarding children, although they planned to complete level three safeguarding children training. Safeguarding training also included PREVENT training which is about safeguarding people and communities from the threat of terrorism.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. There was a university safeguarding policy which identified the process for noticing, checking and sharing any safeguarding concerns. Staff were able to describe examples of when they may need to raise a safeguarding concern, although they reported they had not yet needed to report any safeguarding concerns.

Staff knew how to make a safeguarding referral and whom to inform if they had concerns. There were named safeguarding leads within the university who made referrals to relevant agencies where appropriate when concerns were raised. In addition, there was a safeguarding lead at the local acute trust who could be contacted for advice and support.

Disclosure and Barring Service (DBS) checks were completed through the university and updated every three years. We saw that both staff had an up to date DBS check.

There was a chaperone policy which staff followed. The policy set out the roles of formal and informal chaperones. A formal chaperone was an employee of the University of Wolverhampton, with appropriate training.

Diagnostic imaging

There was access to male and female chaperones who were DBS checked and were able to be present in the scan room during the scan procedure. An informal chaperone was described as a family member or friend. The information leaflet about having a DEXA scan that was sent out to patients with their appointment letter advised patients that they could bring an informal chaperone with them to the appointment. It did, however, state that they would have to wait outside the scan room; this was due to the need to protect visitors from unnecessary exposure to radiation. If chaperones were used this was documented in the patient's record. We saw posters on the scan room door and in the waiting area advising patients that it was their right to request a chaperone if they wished.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, hand hygiene audits were not routinely completed.

The clinical area and waiting area were visibly clean and had suitable furnishings which appeared clean and well-maintained. All chairs in the waiting area were made of wipeable material.

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. There was a cleaning schedule which cleaning staff followed. Cleaning tasks included the cleaning of chairs and other furniture, sinks, and floors and the emptying of bins and refilling of hand gel dispensers. Staff completed a checklist and signed this daily to evidence cleaning tasks had been completed in line with the checklist requirements. We saw the checklists had been consistently completed since the service opened in February 2019. The manager told us they had completed an audit of compliance with the cleaning checklist in October 2019 and had fed back any areas for improvement to the cleaning team. We saw evidence of the audit compliance score sheet and subsequent action plan. The service planned to complete a cleaning audit every month, but this was not yet in place.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed the radiographer decontaminating their hands before and after each patient contact.

There was a handwash sink in an office adjoining the scan room which was planned to be moved into the scan room in December 2019. As the sink was not in the same room as where the scan took place, this meant that patients could not observe staff had decontaminated their hands. We noted that the sink did not have sensor or elbow operated taps which meant that taps could not be turned off by users without them contaminating their hands.

There was a hand hygiene poster displayed in the scanning room by the radiographer's desk. There were hand gel points provided in the waiting area and on entry to the unit, but there were no notices encouraging patients or visitors to decontaminate their hands. The manager told us they had observed the radiographer following good hand hygiene practices but there had not been any formal hand hygiene audits completed. Although we had observed staff decontaminating their hands, due to the lack of routine hand hygiene audits, we were not assured there were robust processes for the service to be able to demonstrate hand decontamination happened consistently.

There were disposable aprons and gloves available for use by the radiographer in the event of needing to deal with a spillage or bodily fluids. There was a specialist spill kit available for cleaning the floor in the event of a spillage.

Staff cleaned equipment after patient contact. We observed the radiographer using clinical disinfectant wipes to clean the scanner table and the leg rest used during scans, after each patient use. In addition, the radiographer told us they cleaned the scanner equipment every day before the start of each clinic as it was not part of the cleaner's schedule to clean clinical equipment. We saw records from July 2019 to November 2019 demonstrating that this had been consistently completed.

Environment and equipment

Diagnostic imaging

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service had suitable facilities to meet the needs of patients and visitors. The facility was situated on the first floor of one of the university buildings and was clearly signposted. There were two designated parking spaces for healthscan patients close to the building. The service could be accessed by a lift or stairs to the first floor. There was a large waiting area with sufficient seating and a range of information leaflets.

There were separate male and female toilets and an accessible / gender neutral toilet available in the corridor leading to the service's waiting area. The university estates department managed the facilities and building. There was CCTV within the reception area of the service for the safety and security of patients and staff. CCTV usage was covered by the university policy on CCTV code of practice and operating procedures. The policy ensured that CCTV was operated with due regard for the privacy of all individuals.

The design of the environment followed national guidance. There was restricted access to the areas where ionising radiation was used. There was secure swipe card access to both doors in the scanner room. Only authorised staff had the correct swipe card permissions to be able to enter the scanning room, and access was restricted to the senior radiographer and the registered manager. Specific cleaning staff were allowed access to the scanning room out of hours to perform cleaning tasks. All swipe card entry to the scanning room was audited by the university to ensure there was no unauthorised access to the scanning room. There were clear signs advising patients and visitors that they were entering a 'radiation controlled area', that x-rays were in use, and there should be no entry when the red light was on. There were lit signs at both entry doors to the scanner room which identified that there were 'x-rays on' when the scanning room was in use.

Staff carried out daily safety checks of specialist equipment. There was an equipment quality assurance (QA) programme which was completed by the senior radiographer each day. This included checking that the 'x-rays on' sign was working and performing system calibration and software testing processes. As part of this

process, a phantom test was performed which tested the mechanical operation of the DEXA machine. A phantom is a specially designed object that is scanned to evaluate, analyse, and tune the performance of the scanning machine. There was a feature built into the scanning machine which prevented it being able to perform scans unless these daily checks had been completed. We saw a log that demonstrated that these tests had been consistently completed since the service had been in operation. These daily tests produced compliance graphs and staff told us that the machine would not work if the tests produced results outside of the compliance parameters. In addition, the scanner stored data relating to radiation doses delivered which could be monitored via software accessed on the computer.

There was a service contract for the scanner with the manufacturer which included a six-monthly service and a responsive breakdown service in the event of equipment failure. We saw the latest copy of the service report which had been completed in July 2019.

The only other equipment in the service was a set of column scales with built-in height measure. These were battery operated and were therefore not required to be electrical safety tested. However, the radiographer did perform routine calibration checks on the scales using weights from the university gym.

The service had enough suitable equipment to help them to safely care for patients. There was one DEXA scanner which was not used at full capacity at the time of inspection.

Staff wore dose monitor badges to monitor their levels of radiation exposure. These were returned to a local hospital every three months, who produced a report and sent replacement badges. We saw the latest dose badge report for the senior radiographer from September 2019 which showed that they had received low levels of radiation exposure which were far below levels where there were known increased risks.

Staff disposed of clinical waste safely. There were separate bins in the scanning room with different coloured bags for household and clinical waste.

The service managed hazardous substances, such as cleaning chemicals, in accordance with the Control of

Diagnostic imaging

Substances Hazardous to Health Regulations 2002 (COSHH). All cleaning products were locked away in a separate cleaning cupboard which only cleaning staff had access to.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff completed risk assessments for each patient on arrival to ensure they got the right scan at the right time. There were processes to ensure referrals were complete and requests for DEXA scans were justified. Referrals received by the service were date stamped when received and checked to ensure four points of patient identifiable information was provided, the referring clinician information was completed and that clinical medical justification for the scan was completed. Clinical justification had to be in line with the referral criteria.

Referrals were also checked on an internal system for duplication and evidence of a previous DEXA scan being undertaken in the previous two years. Any referrals where information was not complete, referral criteria were not met, or previous scans had been performed in the last two years, were declined. These processes ensured that patients did not receive unnecessary exposure to ionising radiation in accordance with local radiation rules and IR(ME)R 2017 Regulations.

The service followed the Society and College of Radiographers 'pause and check' checklist which included confirming patient's identity, the site to be scanned and justification of the scan. Pause and check information posters were displayed in the scan room to prompt staff. We observed the radiographer performing a three-point identification check with patients before scans were performed. They checked with patients they understood why they had been referred and discussed any known risk factors which indicated that patients met the referral criteria for a scan. If there was any discrepancy between the referral information and what the patient told the radiographer, the scan would be postponed until the information could be confirmed with the referring consultant.

Only consultants from the local NHS trust could refer patients for a DEXA scan. This meant that the service received appropriate referrals and scans could be justified in accordance with national guidelines and the service's standard operating procedure.

Staff knew about and dealt with any specific risk issues. The service ensured that any women of childbearing age were asked about their last menstrual period (LMP) date or date of their menopause to identify if they were or could be pregnant to ensure any women who could be pregnant were not exposed to radiation.

Staff shared key information to keep patients safe when handing over their care to others. The senior radiographer was also a reporting radiographer and produced scan reports following DEXA scans, which were sent to the referring consultant. The reports were sent by secure email account and included patient identification details, scan details, fracture risk assessment scores and management advice and treatment recommendations. If there was a suspected abnormality identified this was reported back to the referrer and there were documented processes to follow if it was felt there was a need for patients to access additional urgent diagnostic imaging.

If any patients became unwell whilst in the clinic, both the registered manager and radiographer were first aid trained. Additional first aid support was available from other first aid trained staff in other parts of the building. There was a first aid box in the clinic containing basic equipment such as dressings and eye wash. The box contents were checked by the radiographer to ensure no items were missing and all items were in date. There was no policy for the requirement to check the first aid box, but the radiographer told us it was generally done monthly. We saw that there were records demonstrating that it had been checked most months although the log was not completed from June 2019 to October 2019. If any patients suffered a medical emergency whilst at the clinic, staff were trained in basic life support and could commence urgent treatment. There was no resuscitation trolley or equipment on site except for a defibrillator unit in another area of the building. The policy was for staff to call 999 if patients required emergency treatment. There was also an internal number to call to alert university security staff of any emergency, so they could raise security barriers to allow emergency vehicles access.

Diagnostic imaging

The radiographer was the named Radiation Protection Supervisor (RPS) for the service and was responsible for ensuring compliance with the Ionising Radiations Regulations 2017 through the implementation of local rules for radiation. They were supported by a Radiation Protection Advisor (RPA) who was based out of area. Support offered by the RPA included inspection of plans for installation of new equipment, annual site inspection visits, and provision of annual IR(ME)R update training. The radiographer told us that although there was a named RPA, they could contact any member of that team for advice or support by email or telephone. They told us the support was easily accessible.

As part of the annual site visits a report was produced which included a review of the local rules document, compliance with referral guidance, and completion of regular scanner machine checks. We saw a copy of the latest report dated June 2019 which identified four points of good practice and 12 recommendations. We saw all the recommendations had actions against them to make the required improvements.

The service had a local rules document for the use of ionising radiation in the controlled scanner area. We saw the local rules had been updated in June 2019 following a review as part of the RPA site visit and a recommendation to ensure content and reference information was up to date.

Scan result information enabled the radiographer to use a fracture risk assessment tool to calculate a percentage risk figure of the likelihood of fracture based on the bone density scan findings. This score was used to calculate a RAG rated national osteoporosis guideline group (NOGG) score of red, amber or green, which enabled treatment recommendations to be made by the radiographer to the referring consultant.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service employed one full time equivalent radiographer and they were supported part time by the registered manager for the service who held a principal lecturer post at the university. Only the radiographer, who was registered with the health and care professions council, delivered DEXA scans. The radiographer had completed additional training in DEXA scans to ensure they were suitably skilled for their role. The service was not working at full capacity at the time of inspection and we were told that the staffing was adequate. The manager told us this would be reviewed if there was an increase in demand on the service.

There were no cover arrangements for when the one radiographer was absent on holiday or sick. However, the manager told us an agreement had been made with a local locum agency to be able to provide a suitably qualified radiographer to complete DEXA scans if the radiographer was off work unexpectedly for more than two weeks. The service had a guidance document which identified the preferred locum agency and the processes for requesting and inducing an agency member of staff, if the need arose.

The radiographer mostly worked in the clinic as a lone worker, but the risks associated with this had been minimised. There was a university lone worker policy and systems to protect lone working staff. For example, there was CCTV recording in the clinic waiting area which was linked to the university security and a panic button in the office adjacent to the scanner room. Since doors to the scanner were controlled access, the radiographer could prevent unauthorised persons accessing the scanner room and lock themselves in the room if they felt unsafe. There were staff available in other areas of the building if the radiographer needed assistance.

Records

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

Patient records were comprehensive, and staff could access them easily. Referral information included patient details, current medication, past medical history and risk factors and referrer information. The radiographer checked these details with patients and signed the form to say this had been completed. Following completion of

Diagnostic imaging

the scan the radiographer recorded the area scanned, the date of scan, radiation dose to the patient and name of radiographer on the same form. Information about a patient's risk factor score based on their bone density results was collated and added to the paper form.

Records were stored securely. The paper referral forms were securely stored in a locked filing cabinet when not in use. Images taken by the scanner were sent to the computer which had password protected access. There was a backup external hard drive where images were downloaded to each week. This was stored in a fireproof container in a locked cupboard in a locked office to ensure the images were stored safely and securely.

The radiographer had additional training as a reporting radiographer and produced electronic reports to send to the referring consultant. Reports were sent to consultants by secure NHS email. Copies of the report were also sent to the local hospital's imaging department, where the referring consultants worked. This meant that reports were also stored on the hospital systems, so they were readily available for staff involved in the patient's care and there were no delays in staff being able to access their records. The radiographer aimed to turn around reports in 24 hours, which was identified as an internal target in the Healthscan referral criteria, reporting standards and incidental finding procedures document. However, there was no key performance indicator for report turnaround time and times were not routinely monitored or audited. The radiographer told us they had always managed to complete and send scan reports within 24 hours.

At the time of inspection, image quality and report quality were not monitored or audited within the service.

Medicines

The service did not require systems and processes to safely prescribe, administer, record or store medicines as no medicines were used by the service.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents but did not routinely share lessons learned with the whole team. When things went wrong, staff apologised and

gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff were able to give examples of when they would need to report an incident. There had only been one, non-patient related incident reported since the service became operational in February 2019.

Staff told us they would raise concerns and report incidents and near misses in line with provider policy. There was an incident reporting policy which staff could use for guidance.

Staff knew how to report serious incidents, such as unintended exposure to ionising radiation, in line with trust policy. No serious incidents had been reported by the service since it became operational in February 2019.

There is a requirement under the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017 to report any accidental or unintended exposure to ionising radiation and investigate this. The service radiation protection supervisor was required to report any radiation incidents to the radiation protection advisor. There had not been any reportable radiation incidents since February 2019 when the service was set up. There was a process documented in the Healthscan local rules for staff to follow in the event of an unexpected dose to a patient. The scanner could be emergency stopped by the radiographer from a button on the computer screen and the equipment would not be used again until it had been inspected by an engineer. Staff were advised to estimate the unintentional dose delivered to the patient and report it as a near miss to the Health and Safety Executive (HSE).

The service had not had any never events since it became operational in February 2019.

Staff understood the duty of candour and were able to explain when it would need applying. There was a duty of candour process set out in the Healthscan complaints policy for staff to follow. They explained they would be open and transparent and would give patients and families a full explanation if and when things went wrong.

Diagnostic imaging

Managers told us they would investigate any incidents thoroughly and involve patients and their families in this process if appropriate.

There was no routine process for staff to receive feedback from investigation of incidents, both internal and external to the service. There was no standing agenda item at meetings to discuss incidents and share any learning. The manager told us if they had any incidents to discuss they would add them to the meeting agenda under any other business.

Safety alerts relevant to the service would be shared by the radiation protection advisor by email and staff would be advised of any actions they needed to take. We were assured that there was a process in place for sharing of relevant safety alert information.

Are diagnostic imaging services effective?

We have not previously rated this service and we do not currently rate effective for diagnostic services.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service followed the university policies and had some Healthscan specific policies and procedures. Policies were stored on a shared drive which all Healthscan staff had access to. In addition, there was a paper list of policies and schedule for review. Staff told us that policies were generally updated annually or sooner if there was a change and an update was required sooner.

Most policies we reviewed were in date, had a version control, and had a date for next review. However, there was some inconsistency with Healthscan policies and it was not always clear if all policies were in date or when they had last been reviewed.

Delivery of care standards were set out in documents such as the DEXA standard operating procedure and

handbook which aligned practice requirements to current evidence-based guidance including NICE guidelines for osteoporosis: assessing the risk of fragility fracture, clinical guideline [CG146].

The service had local rules for DEXA scan procedures in relation to the use of ionising radiation which were produced from the Ionising Radiation Medical Exposure Regulations (IR(ME)R) 2017. The local rules provided evidence-based guidance on staff training, radiation protection supervisor and advisor requirements, management of controlled areas, pregnant patients, equipment maintenance and staff dose monitors.

The annual site visit by the radiation protection advisor monitored the service's compliance with IR(ME)R 2017 and reviewed the local rules to ensure they were up to date and reflected current guidance. The radiographer also worked in accordance with the Society and College of Radiographer's professional standards by following guidance such as the 'Pause and Check' to ensure that the right patient received the right scan at the right time.

Part of the role of the radiation protection advisor was to provide information updates to the radiation protection supervisor, such as any new guidance from the Health and Safety Executive.

Nutrition and hydration

Patients spent a very short time at the clinic, up to a maximum of 30 minutes, and therefore did not require access to food or drinks whilst at the clinic. There was a water machine available for patient use but this was out of order at the time of our inspection.

Pain relief

Staff asked patients if they were comfortable before the scan was started. They provided a pillow and knee rest for the patient's comfort and support during the scan procedure. Pain relief was not prescribed or administered by the service.

Patient outcomes

Staff did not routinely monitor the effectiveness of care and treatment. They did not use patient outcomes or complete regular audits. They were therefore unable to use any outcome findings to make improvements and achieve good outcomes for patients.

Diagnostic imaging

There were no national audits the service was required to participate in. However, there was no regular review of the effectiveness of care through any local audit programme or peer review. Managers and staff were therefore unable to use audit results to improve patients' outcomes as this information was not routinely collected.

The service did not have any key performance indicator targets as there was no formal written contractual agreement between the local NHS trust or clinical commissioning group.

The service did have some internal targets for patient wait times and report turnaround times, but these were not monitored. Patient satisfaction data was collected but at the time of our inspection this was not routinely audited or reported. However, staff told us they had just begun a process to review this data.

There had been a cleaning audit but there were no other audits happening regularly in the service. Audits relating to hand hygiene, wait times from referral to treatment, clinic wait times, report turn around times, records and image and report quality were not carried out.

The manager told us there were some planned audits which included audit of patient satisfaction on a monthly basis, appointment waiting times from September 2019, last menstrual period check from December 2019, hand hygiene from January 2020 and number of repeat examinations from February 2020. However, these audits were not routinely happening at the time of our inspection. We were not assured that staff had oversight of their performance and outcomes. This meant that they may not recognise when there was a need for improvements to be made to deliver effective care and achieve good patient outcomes.

The provider was not accredited with the Imaging Service Accreditation scheme.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The

radiographer who performed the DEXA scans was a health and care professions council registered radiographer and had completed additional training specific to DEXA scanners.

Managers made sure staff received any specialist training for their role. The radiographer had received initial training on the use of the scanning machine from the manufacturer and annual update training was provided. The manufacturer also provided biannual continuing professional development events which were free for the radiographer to attend. Additionally, the radiographer had completed postgraduate training to qualify them to be a reporting radiographer and had completed radiation protection supervisor (RPS) training. There were RPS training updates available every two to three years which the radiographer had completed to ensure they remained up to date. The radiographer also received advice and support in their role as RPS from the radiation protection advisor (RPA) who was based at a local hospital.

Managers had an induction plan to follow if any agency staff were required and told us this would be delivered to any new staff who started work in the service.

Managers supported staff to develop through yearly, constructive appraisals of their work. We saw within the last year, the radiographer had received an appraisal from the registered manager. The appraisals process required staff to complete a self-review and identify areas for development alongside a review of the previous year's objectives. Objectives for the following year were set alongside an action plan detailing how they could be achieved. The registered manager had recently completed a period of probation, during which their performance and progress was regularly monitored. Appraisals were not completed during the probation period, but the registered manager was planned to receive their first appraisal in May 2020.

Managers supported staff to develop through regular, constructive clinical supervision of their work. The registered manager met with the radiographer to review their work performance, training compliance and clinic schedules. These supervision meetings were planned quarterly but had been happening more regularly since there had been a change of registered manager to enable them to fully understand the service. Part of the supervision process also included observation of the radiographer's clinical practice.

Diagnostic imaging

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The radiographer was supported by the manager to attend regional osteoporosis society meetings with other radiographers, radiologists and nurse specialists. These were held six-monthly and provided a training opportunity which was relevant to the radiographer's role. In addition, the university research centre held monthly interprofessional meetings relating to bone health, falls and fractures which the radiographer could attend to keep up to date. The radiographer was also supported professionally through membership of their professional body, the Society of Radiographers.

The manager supported the learning and development needs of staff. The radiographer was currently undertaking a postgraduate doctoral degree (PhD) in the prevention of secondary fractures following a fall, which was being funded by the university who employed them. The manager ensured that the radiographer had protected time to complete this.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

There were effective working processes for consultants to refer patients to the radiographer for DEXA scans. The radiographer worked closely with consultants to ensure appropriate referrals were received and there was sufficient information on the referral form for the radiographer to justify the scan. Information about scan results was shared with referring consultants. Copies of the scan report were sent electronically to the imaging department at the referring hospital, which meant that consultants had easy and timely access to these.

The radiographer attended regional multiprofessional meetings specific to the management of osteoporosis, where different staff could share knowledge and good practice.

Staff did not have direct access to refer patients to other disciplines or for mental health assessment but told us that if they had any concerns about a patient presenting for a scan they would refer them back to the referring consultant or the patient's GP.

Seven-day services

Key services were available five days a week to support timely patient care.

This was appropriate since DEXA scans are not an urgent intervention. Scans were available from 9:00am to 3:30pm Monday to Friday which provided sufficient capacity to meet the demand in the number of referrals.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information for promotion of healthy lifestyles and support. We saw a wide range of information leaflets available in the clinic relevant to patient's medical conditions. For example, there was information on osteoporosis, keeping active, and healthy eating. In addition, there was information on national priorities to improve the populations health, such as smoking cessation and alcohol intake. The service had access to health promotion material from Public Health England on request. They had a display board in addition to the information leaflets, which they used for topical information such as smoking cessation campaigns during October (Stoptober).

Staff assessed each patient's health on arrival and provided support for any individual needs to live a healthier lifestyle. The radiographer reviewed patient's medical history with them before starting a scan and discussed risk factors for bone fracture with them such as smoking and alcohol intake, levels of physical activity, and appropriate diet. They would provide appropriate information leaflets and advice to patients as required.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. However, they did not always follow national guidance to gain patients' consent as they did not document that consent had been gained. They were not always able

Diagnostic imaging

to support patients who lacked capacity, or who were experiencing mental ill health, to make their own decisions. Staff did not complete mandatory Mental Capacity Act training.

Staff could not demonstrate that they understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005 as they did not receive training in this. Staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care. Although the informed consent policy referred to the Mental Capacity Act (2005) and the need to assess if patient's had capacity to make decisions, we were not assured staff had the knowledge or skills to assess patient's capacity as they had not received training in the Mental Capacity Act (MCA). Staff were not required to complete MCA training as part of their mandatory training requirements and neither the radiographer or the registered manager had completed any MCA training.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. There was an informed consent policy which staff followed. The policy identified the importance of staff needing to obtain valid consent before starting a diagnostic investigation for a patient. We saw that staff supported the involvement of patients in their care by providing information about the scan process, including the risks and benefits, for them to make an informed decision about having the scan. We observed the radiographer explaining the scan procedure to patients before they performed a scan and asking them if they were happy to proceed with the scan. The explanation included a description of the area to be scanned and the reason for the scan request, as well as the risk of low dose radiation. Patients who provided verbal consent and implied consent by getting on to the scan table were then scanned.

Staff did not record consent in the patients' records. Although there was no requirement for patients to provide written consent for the scan, the radiographer did not document that a conversation about consent to the scan had taken place. There was no space on the patient record form for the radiographer to record that informed

consent had been gained. We raised this with the radiographer and manager who told us that they would review their documentation to enable them to record the conversations about consent.

When patients could not give consent, staff were unable to make decisions in their best interest, taking into account patients' wishes, culture and traditions. For any patients where there was a concern about their capacity to consent to a scan, staff deferred the scan and referred patients back to their referring consultant. There were no systems to enable staff to support patients to make best interests decisions. The policy stated that any patient who could not understand, retain and weigh up information in order to make a decision should not be scanned. In this situation the radiographer was to contact the referrer and advise them that informed consent could not be obtained. The referrer would be asked to re-assess the patient for capacity in relation to consent since the radiographer did not have access to all other third parties to decide if a scan was in the patient's best interest.

Staff could describe and knew how to access the informed consent policy. However, there was no support identified to assist staff in assessing patient's capacity in relation to them being able to provide informed consent.

Are diagnostic imaging services caring?

Good 

We have not previously rated this service and cannot therefore compare ratings with the last inspection. We rated it as **good**.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. The radiographer spent time explaining the scan procedure to patients and had a friendly and calm approach. We saw staff took time to ensure that patients

Diagnostic imaging

were comfortable throughout the scan. They spent time adjusting the pillow and knee support before they started the scan to ensure patients were not in any discomfort during the procedure.

Patients said staff treated them well and with kindness. Patients we spoke with said they had received good care and their experience of the service had been positive.

Staff followed policy to keep patient care and treatment confidential. We noted that all conversations about patient's care were held within the private scan room and not in the public waiting area.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff had received a once only training session in dementia care and recognised that some patients may need additional support or reassurance during the scan procedure. This could be provided by patients bringing an informal chaperone or through the service offering a formal chaperone.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff told us the local population was culturally diverse, and they recognised the need to consider individuals needs such as different languages. Staff had access to some information leaflets in different languages which they could use to support discussions with patients about their condition.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff recognised some patients may be anxious about the scan procedure and they took time to show them the scanner and explain the procedure before the scan was started.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. There were a wide

range of information leaflets available to help patients understand their condition and follow healthy lifestyle advice. These included information about national support groups.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. An information leaflet about DEXA scans was sent out to patients along with their appointment letter which provided details of the scan procedure. This included what happens during a scan, how long it takes, what the risks are, and any preparation requirements. When patients arrived for a scan, the information was discussed with them to ensure that they understood it and could make an informed decision about having the scan. Following completion of the scan we heard the radiographer give patients information about how and when they would receive their scan results. For patients referred by rheumatology consultants, the radiographer gave patients contact details of the rheumatology clinic, so they could chase up an appointment to receive their scan results if they had not heard anything within two weeks of their scan.

Staff talked with patients, families and carers in a way they could understand. We heard the radiographer using simple language without jargon when explaining the procedure to patients.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The radiographer told us they encouraged all patients attending for a scan to give feedback on the service they had received. They were given a Healthscan patient satisfaction questionnaire after their scan which they could return in a sealed box at clinic reception or by post. The questionnaire was based on the Royal College of Radiologists 'Patient Satisfaction with the Radiology Department' questionnaire 2017. During our inspection the radiographer was in the process of completing an audit of the satisfaction survey results from October to December 2019. 14 responses had been received at the time of inspection which demonstrated that 100% of patients rated their overall experience as excellent.

Diagnostic imaging

Patients gave positive feedback about the service. Feedback comments on the patient satisfaction questionnaire included:

- Professional, courteous and everything on time. Good parking facilities, thank you
- Very pleasant Radiographer. Clean and tidy waiting room
- Friendly and helpful staff. Very pleasant lady dealt with me

The service also participated in the Friends and Family Test. During the period February to November 2019, 134 patient friends and family testing feedback cards were returned. This was a response rate of 19.5%. Feedback data showed that 100% of patients said they would recommend the service to their friends and family.

Staff could give examples of how they used patient feedback to improve daily practice. The radiographer told us that the service information leaflet provided with patient's appointment letters had recently been redesigned to include a photograph of the scanner machine and a campus map, in response to patient feedback for more detailed information.

Are diagnostic imaging services responsive?

Requires improvement 

We have not previously rated this service and cannot therefore compare ratings with the last inspection. We rated it as **requires improvement**.

Service delivery to meet the needs of local people

The service could not demonstrate that they provided care in a way that met the needs of local people. Although staff told us that patients could access the service when they needed it and received the right care promptly, they could not provide evidence to support this. There was no formal contractual arrangement or requirement to monitor performance targets to enable the service to demonstrate that it was meeting the needs of the local population.

The service told us that they were able to accept referrals and perform scans without delay. However, we saw no evidence to support this view.

There was some performance monitoring between the university management and the Healthscan staff who together had formed a Healthscan board. The board reviewed basic performance information such as operating capacity and progress against financial targets.

Facilities and premises were appropriate for the services being delivered. The service was situated in a university building on the first floor. There was lift access, a large waiting area, and separate sex toilet facilities. There were two designated parking spaces close to the building for use by Healthscan visitors. There were currently no transport arrangements between the service and transport providers, but we were told that the referring department could arrange transport for patients if required.

Appointment letters provided information about the location of the clinic which included a telephone number and a clear map of the campus where the building was located. The letter explained how to enter the campus through the security barrier and a photograph of the building was provided so patients could identify the correct location.

Appointments were usually available from 9am to 3:30pm Monday to Friday but the radiographer had flexibility to offer earlier or later appointments on request. Weekend appointments were not available.

Managers monitored numbers of missed appointments and acted to minimise missed appointments. From August to October 2019, there had been 15 missed appointments out of 255 booked appointments which was a did not attend (DNA) rate of 0.06%. Managers monitored and reported DNA rates to the Healthscan board. Managers ensured that patients who did not attend appointments were contacted. Any patient that did not attend for an appointment was contacted by telephone by the radiographer on the following day to check that they had received their appointment letter and to ask why they had not attended. If patients still wished to attend they were offered a further appointment, but if they failed to attend this appointment they were referred back to the consultant.

Diagnostic imaging

There was no formal contractual agreement with the local NHS trust or the local clinical commissioning group for activity delivered or for any performance activity targets such as number of scans or wait times. Staff did not have any regular engagement with the local hospital or commissioning body to review whether the service was meeting the needs of the local population. There was no written contractual agreement between the local clinical commissioning group and the Healthscan service. There was an arrangement between Healthscan and the local hospital whereby the service invoiced the hospital on a monthly basis for activity delivered. There were no activity targets set out by the hospital for the service and there were no regular meetings held between the service and the hospital. The manager told us that there were some informal discussions between the university business manager and the business development teams at the local acute trust to develop a contract in the future but there was no timescale for this to be achieved.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff recognised patients with mental health conditions may require additional support and asked referrers to highlight any additional support needs on the referral form. Patients were able to bring family members or friends with them to the clinic although they were informed that they would not be allowed to be present in the scanner room during the scan. However, in exceptional circumstances, the radiographer had discretion to allow family members to stay in the room during the scan. There was a three feet rule which had to be followed and required family members to stand in the corner of the room at least three feet away from the scanner to avoid the field of radiation.

The service had information leaflets available in languages spoken by the patients and local community. We saw that some leaflets were available in Polish and Punjabi, which was appropriate to the local community.

Managers made sure staff, patients and carers could get help from interpreters when needed. The need for interpreter support at appointments was highlighted on the referral form. If support was required for patient's whose first language was not English, the referring trust would arrange for an interpreter to attend the scan appointment with a patient.

Access and flow

Managers reported that patients could access the service when they needed it and received the right care promptly. However, there was no evidence that patients were able to access the service in a timely way. Waiting times from referral to treatment, and report turnaround times were not formally monitored or reported.

Managers did not routinely monitor waiting times from referral to appointment, however, it appeared patients could access services when needed and received treatment within locally agreed timeframes within the service.

Data provided by the service indicated it had been operating at an average of 48.3% of capacity from August to October 2019. Staff told us they aimed to see all patients for a scan appointment within two weeks of receiving a referral. We saw this internal target was outlined in the HealthScan referral criteria, consent, reporting standards and incidental finding procedures document.

Staff told us that there was no issue with waiting times for scans as the service was not working at full capacity. The manager said they were confident patients were seen within the two-week target. However, when we asked staff and managers how compliance with this internal target was monitored they told us there was no process to do this. They did not routinely collect or monitor data about waiting times from referral to scan. There was no requirement to report waiting time data to the referring local NHS trust, local clinical commissioning group or the Healthscan board.

Wait times in the clinic from appointment time to scan were not routinely monitored. However, staff told us as the service was not working at full capacity, patients did not have to wait for their scan and were always seen

Diagnostic imaging

promptly on arrival at the clinic. We were unable to corroborate this information as the service did not collect data, or report on, waiting times from appointment to scan.

Managers worked to keep the number of cancelled appointments to a minimum. The manager told us that there had been no cancelled appointments by the service since it started in operation in February 2019.

No patients had had their appointments cancelled at the last minute, but the manager told us that if appointments were cancelled they would make sure they were rearranged as soon as possible.

Learning from complaints and concerns

The service had not received any complaints since it was set up. There was a complaints policy to ensure the service treated concerns and complaints seriously and investigated them. However, it was not always easy for people to give feedback and raise concerns about care received as complaints information was not clearly displayed by the service. There was no process for routinely sharing any lessons to be learned with all staff and there were no timescales for written responses to complainants outlined in the complaints policy.

Staff understood the policy on complaints and knew how to handle them. Staff were able to describe the complaints process and emphasised that an open and honest approach would be taken to any concerns or complaints raised. A local resolution approach would be taken first but if this failed the complaint would be escalated to the registered manager or the associate dean of the university if necessary. The manager told us they would aim to provide a written response to all complaints that were escalated within seven days. This target was not identified in the complaints policy. The policy required an acknowledgement of the receipt of any escalated complaints by the manager within three working days but there was no target identified for providing a written response to complainants. The complaints policy also identified that patients should receive feedback from managers after an investigation into their complaint.

Managers understood the need to investigate complaints but had not been required to investigate any complaints to date.

Patients, relatives and carers may not always know how to complain or raise concerns. Although we saw there were complaints information leaflets in the leaflet rack in the waiting area, these were not easily identified. There was no poster displaying the complaints process or information informing patients how they could complain. We did not feel complaints information was clearly visible to patients and therefore not all patients would know how to raise a concern or complaint.

There was no process for sharing feedback from any complaints, should they occur, with staff or the Healthscan board. Complaints review was not a standing agenda item at the Healthscan board meetings. This meant there was no mechanism for sharing any learning identified to improve the service. However, the manager told us any complaints arising would be discussed in any other business if required.

Are diagnostic imaging services well-led?

Requires improvement 

We have not previously rated this service and cannot therefore compare ratings with the last inspection. We rated it as **requires improvement**.

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The service was led and delivered by the senior radiographer on a day to day basis. They were suitably skilled and experienced to manage the service operationally and deliver DEXA scans to patients. The radiographer also had the title of facility manager. They were supported by a senior member of university staff who was a registered nurse and the registered manager

Diagnostic imaging

for the service. The registered manager had a substantive post with the university as a principal lecturer and offered support to the facility manager as required but was not based at the clinic.

The facility manager and registered manager were supported by three associate deans and directors for the university. One of these was the associate dean and director of the institute of health. The managers told us they were very visible in the clinic, visited regularly and were approachable. The managers and the associate deans and directors together formed a Healthscan board which received monthly reports from the managers to keep them up to date on any service issues. The board met bi-monthly to review and discuss the reports.

Vision and strategy

The service had a vision for what it wanted to achieve but did not have a strategy to turn it into action. The vision was aligned to the local university's values but was not aligned to the local health economy. Leaders and staff were not able to monitor progress of achievement of the vision statement as there was no strategy or objectives to support its delivery.

Healthscan worked in accordance with the university's vision and strategy. The university's strategy was underpinned by a set of core values which were 'We will behave respectfully and ethically, in all that we do; we will be inclusive and fair in our interaction with each other and with our wider community; we will act professionally, transparently, confidently, collaboratively and challengingly when engaging with our communities locally and globally.'

There was a five-year strategic plan to achieve the university's vision. Healthscan had a five-year vision statement based on the university's values, which was to be 'a compassionate and caring provider of clinically excellent diagnostic imaging, where motivated staff use best evidence to work in partnership to provide services in our diverse community.'

Managers said they had not yet developed a strategy or objectives for achieving the vision. This meant that progress against delivery of the vision could not be monitored.

The vision was only aligned to the university strategy and values and was not aligned to local plans in the wider health economy.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients and staff could raise concerns without fear.

There was a strong focus on meeting the needs of patients who used the service. Staff were friendly and supportive and offered flexibility in appointments to try and accommodate patient's needs. Many patients had left positive comments about the staff behaviour and attitude.

Staff told us the service was a nice place to work and that they were well supported by the university. The radiographer described how they could easily access support from other staff in different departments within the facility building. There were monthly interprofessional meetings in the university's research centre which offered further support. The registered manager told us they held regular meetings with the senior radiographer which included checking on their wellbeing. The university offered further support to staff through a staff wellbeing page on the intranet, the availability of an employee assistance programme and the offer of discounted gym membership.

The university's values included being open and transparent and this was reflected in the Healthscan complaints policy. The policy described openness as enabling concerns and complaints to be raised freely without fear, with questions asked being answered. Transparency was described as the requirement for accurate information about performance and outcomes to be shared with staff, patients, the public and regulators. There was an expectation that all HealthScan staff must be honest, open and truthful in all their dealings with patients and the public, and that organisational and personal interests must never be allowed to outweigh the duty to be honest open and truthful.

Diagnostic imaging

Staff were encouraged to develop through setting objectives in appraisals. Achievement of objectives was supported by the university. The radiographer was currently being supported by their line manager, and by the university financially, to complete a post graduate doctoral degree.

Staff safety was a priority. There was a lone working policy and security systems in place to ensure the safety and well-being of staff.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities. There were opportunities to meet, discuss and review the service delivery, which included internal performance targets. However, performance of the service was not routinely reported on to stakeholders. There were no clear governance arrangements in place between the service and the local trust as there was no contract set out to detail service delivery and performance requirements.

There was a clear governance structure within the university into which the registered manager for the service reported. The registered manager reported to the associate dean and director for the institute of health, who reported to the dean of the faculty of health and wellbeing. The dean for the faculty reported to the deputy vice chancellor who in turn reported to the vice chancellor of the university.

A Healthscan board had been set up for information sharing between the service and the university to provide oversight of the facility, its management, resources, and staffing. We were told board meetings were held bimonthly and were attended by the associate director, dean of the faculty, the faculty business manager, the registered manager and the senior radiographer. The board reported up to the university's faculty board. However, there had only been two meetings held to date since the service began operating in February 2019. Managers told us that a board meeting originally scheduled for March 2019 was cancelled due to key board members being on leave. An extraordinary meeting was

held in September 2019 and the first scheduled board meeting was held on the 8th of November 2019. We saw that future meetings had been scheduled for February, April and June 2020.

There was a brief standing agenda for the board meetings which listed priority items for discussion at each meeting rather than following a set agreed format for reporting issues, and performance in a structured routine way. The registered manager and senior radiographer told us that they produced quarterly information reports for the Healthscan board members. We saw that the report information was presented to the board for discussion at the November meeting. The operational report provided information on the service operating capacity, performance progress against financial targets finances and service user feedback.

Staff within the service were clear about their roles and their responsibilities. There was a clear reporting structure and lines of accountability.

There was a process for managing the radiation protection advisor (RPA) support arrangements for the service. There was a contract between the service and the provider of the radiation protection and medical physics services to identify terms and conditions for the provision of services. The agreement identified the roles and responsibilities of the service radiation protection supervisor (RPS) and the RPA. The contractual agreement included an annual site visit when all the relevant radiation checks and an audit of practice was undertaken by the RPA alongside a review of current policies. However, there were no regular radiation protection meetings between the RPS and any other members of the Healthscan team at the time of inspection.

The previous registered manager had also been a named RPS and used to meet with the senior radiographer to ensure that radiation protection governance was effective. Dose badge reports, scanner service and maintenance issues, quality assurance test results, image and report quality were all discussed at this meeting to provide governance assurance. This information was not reported up to the Healthscan board as it was not formed at this time. There was no local process at the time of inspection for reviewing, monitoring and reporting on radiation protection governance. At the time of inspection, the radiographer was the only RPS on site. We were told that the new registered manager was planning

Diagnostic imaging

to complete RPS training to facilitate a process for providing radiation protection governance assurance but there was no date for this to be completed at the time of our inspection.

There were no governance procedures for managing a service level agreement with third parties as there was no written contractual agreement. Staff told us there had been no formal minuted meetings to date with the local NHS trust with whom there was a service delivery arrangement. Managers told us discussions were under way to schedule a meeting to review the current contractual arrangements to obtain a service level agreement and develop a written contract between the University and the service.

Managing risks, issues and performance

Leaders and teams did not use systems to manage performance effectively. However, they had processes to identify and escalate relevant risks and issues and to identify actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were no processes for providing comprehensive assurance about service performance or for escalating any issues and concerns. Minimal performance data was collected by the service and this information was not regularly monitored, reviewed or reported. There were no agreed key performance indicators with the local NHS trust with whom there was an agreement to deliver the service.

There was no systematic programme of clinical audit to monitor quality or operational performance. Although there were some internal service targets these were not monitored or reported on. There were no regular audits of service performance happening in the service. This meant there was no process to identify areas where action should be taken for improvement.

There was a system for identifying, recording and managing risks. The service had a local risk register where risks were logged, scored and RAG rated. Each risk was dated and had a named risk owner and mitigating actions were identified with target completion dates. We saw that most risks were potential risks and had been

scored as low risk. Actions had either been completed or were on track for completion by the target date. The service followed the university's risk management policy which set out reporting procedures and staff responsibilities. However, there was no process for regular review of the risk register at the time of our inspection.

There was a Healthscan business continuity plan and a university major incident plan which identified procedures for staff to follow in the event of unexpected circumstances such as the loss of facilities, power, staffing, or water or in the event of a major incident.

Managing information

The service did not routinely collect reliable data or analyse it. Staff could find the information they needed but data was not collated in order to enable staff to understand performance and make decisions and improvements. However, the information systems used for patient care were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

There was not a holistic understanding of service performance at any level. Due to a lack of data analysis, staff in the service did not have an oversight of performance relating to quality, service delivery or finance. Performance data was not routinely collected, monitored or reported to stakeholders in the service. This meant the service did not use data for assurance or improvement.

Information technology systems enabled staff to share reports with referring consultants at the local NHS trust in a secure and timely way. Systems were password protected and scan result reports were sent by secure email systems in accordance with confidentiality and access requirements set out in the Healthscan medical records policy. This was in line with General Data Protection Regulation(GDPR) 2018 guidance.

Staff understood how to report radiation incidents in the event of uncontrolled or unintentional radiation exposure. The Healthscan local rules for Dual Energy X-Ray Absorptiometry document, based on ionising radiation (medical exposure) regulations (IR(ME)R) 2017, advised staff to report all incidents or near misses to the Health and Safety Executive.

Diagnostic imaging

Engagement

Leaders and staff actively and openly engaged with patients and staff to gain feedback on their experiences of the service. However, there was no evidence of collaboration with partner organisations to help improve services for patients.

The senior radiographer encouraged patients to provide feedback on their experience of using the service. They had just started collating the feedback data into a report for the Healthscan board to be presented in December 2019.

All patients were invited to complete a patient satisfaction questionnaire after their scan. The questionnaire aimed to help identify areas of service quality and areas where the service could potentially be improved, to further enhance positive patient experience and quality of care. The questionnaire included questions relating to satisfaction with information provision, wait times, the facilities and staff behaviour. There was an opportunity for patients to write additional general comments. Patient's feedback comments were displayed on a 'what you said' board for patients and visitors to see. Staff told us they used feedback to shape service delivery, giving the example of changing the information provided to patients before their appointment to include a large map on the reverse of the appointment letter to enable patients to find the facility more easily.

Staff participated in a university annual staff survey. Results were shared with staff at department level. However, the survey had recently been completed and results were not available at the time of inspection.

There were no formal processes for collaboration with external partners, such as the local NHS trust or

commissioning body, to enable shared understanding of the service delivery issues in order to ensure the service was able to meet the needs of the local population. There was no openness with stakeholders about performance as a result of the lack of any regular formal engagement.

Learning, continuous improvement and innovation

Staff could not demonstrate that they were committed to continually learning and improving services as they did not routinely use quality improvement methods to make service improvements.

Staff did not have an established process to monitor, review and improve service performance and outcomes. Data and information was not routinely used to audit service delivery, meaning that staff had no consistent process to identify the need for any service improvements.

Staff did, however, demonstrate a commitment to their own personal development and were supported by the service to achieve this. The radiographer had been financially supported by the university to undertake a post graduate doctoral degree and told us that the registered manager supported this by allowing protected time for them to complete their studies.

The service was part of a large faculty within the university which meant that they were part of a progressive learning and research community. The service supported wider learning through offering student nurse placements at the clinic and they were exploring the possibility of offering placements to undergraduate radiography students.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The service must ensure that there are effective governance processes in place to monitor, review and report on service performance in order to be able to identify any areas of required improvement. (Regulation 17 (1) (2) a,b,f)
- The service must ensure that all staff complete Mental Capacity Act training to enable them to fully understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005, and be able to assess and support patients who lack capacity to make decisions. (Regulation 11 (1) (2) (3) (4))
- The service should review processes to consistently review incidents, complaints and risk at information sharing meetings.
- The service should consider how complaints information is displayed in patient areas so they can be sure patients know how to raise a concern or make a complaint.
- The service should consider how they monitor and audit image quality and report quality within the service.
- The service should review all Healthscan policies to ensure that there is consistency with the version control and policy review process.

Action the provider **SHOULD** take to improve

- The service should review processes to document patient consent and audit compliance with this requirement.

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 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— a. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); b. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; f. evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).
Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 11 HSCA (RA) Regulations 2014 Need for consent 1. Care and treatment of service users must only be provided with the consent of the relevant person. 2. Paragraph (1) is subject to paragraphs (3) and (4). 3. If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act*.

This section is primarily information for the provider

Requirement notices

4. But if Part 4 or 4A of the 1983 Act** applies to a service user, the registered person must act in accordance with the provisions of that Act.

5. Nothing in this regulation affects the operation of section 5 of the 2005 Act*, as read with section 6 of that Act (acts in connection with care or treatment).

* Mental Capacity Act 2005

** Mental Health Act 1983