

InHealth Limited

Inhealth Diagnostic Centre

Inspection report

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Date of inspection visit: 6 October 2021
Date of publication: 15/12/2021

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

Good



Are services safe?

Good



Are services effective?

Inspected but not rated



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as good because:

- 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 safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care to patients and monitored their pain. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- 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 planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for a diagnostic procedure.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. 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. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- There was limited assurance that ageing equipment was protected by an effective capital replacement programme.
- The management of sharps bins was not always in line with national standards.

Summary of findings

Our judgements about each of the main services

Service

Diagnostic imaging

Rating

Good



Summary of each main service

InHealth Diagnostic Centre is operated by InHealth Limited. The service provides diagnostic imaging services to NHS and private-sector patients from a stand-alone, purpose-built screening facility. We rated the service as good because it was safe, effective, caring, responsive, and well led.

Summary of findings

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Summary of this inspection

Background to Inhealth Diagnostic Centre

InHealth Diagnostic Centre is operated by InHealth Limited. The service provides diagnostic imaging services to NHS and private-sector patients from a stand-alone, purpose-built screening facility.

This location opened in 2010. The centre provides magnetic resonance imaging (MRI) scans, computed tomography scan (CT) scans, dual-energy X-ray absorptiometry (DEXA) scans and ultrasound. The unit is registered with the CQC to undertake the regulated activities of diagnostic and screening procedures. The site provides a service for adult patients aged 16 and above and operates seven days a week between the hours of 7am and 9pm.

About 60% of patients came from NHS referrals through an arrangement with the Clinical Commissioning Group (CCG) and 40% of patients were referred privately or through self-referral. The clinic saw an average of 800 NHS/CCG patients per month and 400 private patients per month.

The service has one ultrasound scanner, a CT scanner, an MRI Scanner and a DEXA machine. Most reporting was completed locally by in-house radiologists. However, the service outsourced to ensure they kept within the reporting turnaround times and national targets when the providers' radiologists did not have capacity.

A review was carried out at the location to assess compliance with the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER17) in June 2021. Overall compliance with IRR17 and IRMER was good. The imaging services manager and radiology staff were aware of the local rules and procedures and these documents are reviewed on a regular basis. Most of the recommendations following this audit related to updating the current documentation to comply with the implementation of the new IRR17 and IRMER regulations. Some minor changes to the procedures were recommended to reflect local arrangements.

The service had not been the subject of an external investigation between August 2017 and September 2021.

How we carried out this inspection

We inspected diagnostic imaging services at this location.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 6 October 2021.

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.

Areas for improvement

Action the service SHOULD take to improve:

Summary of this inspection

- Ensure sharps boxes are fully labelled at the point of first use.
- Ensure work to replace ageing equipment are mitigated through assurances of progress in a capital replacement programme.






Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Inspected but not rated	Good	Good	Good	Good
Overall	Good	Inspected but not rated	Good	Good	Good	Good

Diagnostic imaging

Safe	Good 
Effective	Inspected but not rated 
Caring	Good 
Responsive	Good 
Well-led	Good 

Are Diagnostic imaging safe?

Good 

Our rating of safe stayed the same. 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. The service provided statutory and mandatory training using a combination of 'face to face' sessions and e-learning. We reviewed the staff training matrix and found 100% compliance.

The mandatory training met the needs of patients and staff. It included basic life support, immediate life support for clinicians, infection control, duty of candour, ethics, safeguarding children and adults level two and three, the Mental Capacity Act and Deprivation of Liberty Safeguards, health and safety, manual handling and medication safety.

Staff received training specific to their role. Senior radiographers and the superintendent radiographer had completed assessor training. The superintendent radiographer and one of the senior radiographers were practice educators.

Managers monitored mandatory training using a training matrix and alerted staff when they needed to update their training. Radiologists working under practising privileges and bank staff completed mandatory training with their substantive NHS employer and provided annual confirmation of completion of this training to the service in line with the practising privileges policy. Records provided by the service showed all staff working under such arrangements were up-to-date with mandatory training.

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.

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Staff received training specific for their role on how to recognise and report abuse. Safeguarding children and adults formed part of the mandatory training programme and all staff were trained to level two. The manager was trained to level three and the provider had a national safeguarding lead trained to level four.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. A recent example of good practice occurred when staff working out of hours contacted the local crisis team to report suspected neglect and abuse. The team's quick actions meant a person at risk was protected. The manager shared this example across the provider's network to share learning.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They could access support from senior staff if needed. There had been one safeguarding incident in the previous 12 months. Records showed the incident was investigated and reported in line with the safeguarding policy.

Staff had access to a list of local safeguarding contacts, including for the out of hours crisis team. The list had last been reviewed in March 2021 and the imaging services manager updated this annually.

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.

The service performed well for cleanliness and infection prevention and control (IPC). Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Radiographers were responsible for cleaning the diagnostic equipment. Items were visibly clean and dust-free, and we saw daily cleaning check lists were up to date. Staff used antibacterial cleaning products in line with best practice standards, such as to disinfect ultrasound probes.

A dedicated IPC lead was in post and supported the team to adhere to standards of good practice. They monitored national guidance and updated local policies and training.

Staff followed infection control principles including the use of personal protective equipment (PPE). The service provided staff PPE such as gloves, aprons, and face visors. We observed all staff wore PPE appropriately and adhered to hand hygiene best practice.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Hand-washing and sanitising facilities were available for staff and visitors in the centre. Posters were displayed prominently in waiting rooms and toilets with a visual depiction of World Health Organisation hand hygiene best practice. The manager audited compliance with practice using a series of rolling audits, such as monthly observations of PPE donning and doffing and of hand hygiene. Between January 2021 and September 2021, the team achieved 99% compliance with NHS hand hygiene standards. This reflected 32 audits of 100% compliance and two audits with minor areas for improvement.

Staff introduced enhanced protection measures during the COVID-19 pandemic. This included adjusting appointment arrangements to reduce the numbers of people in the building and extra cleaning for touch points around the clinic. The IPC lead carried out monthly audits of enhanced measures of PPE use during this period. Between May 2021 and August 2021, audits demonstrated consistent levels of compliance. Where the audit highlighted areas for improvement, staff took action. For example, early audits for this process identified a need for staff to wear eye protection if they were in close proximity to a patient. Subsequent audits showed this had been addressed.

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Environment and equipment

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 design of the environment followed national guidance. There were illuminated warning signs outside of the doors to scanning rooms that warned of the risks of radiation and lit up when the equipment was in use. This was in line with the Ionising Radiation (Medical Exposure) Regulations (IRMER) (2017). Patients undergoing MRI scanning had access to a self-contained that included toilets and lockers for personal possessions.

Patients undergoing MRI or CT scans had access to an emergency call buzzer, ear plugs and defenders. Staff played music on request. A microphone allowed contact between the radiographer and the patient at all times.

The MRI scanning room was equipped with an oxygen monitor in line with Department of Health Health Building Note HBN06-13.64. This ensured staff were alerted to any escaping gas that could compromise patient safety. The magnet was also fitted with emergency “off” switches, which suspended scanning and switched off power to the magnet sub-system.

An MRI-safe wheelchair and trolley were available in the scanning room and staff were trained in their use for an urgent evacuation or transfer.

Staff carried out daily quality assurance checks on the imaging equipment. Staff completed checklists and there was evidence of testing all equipment used at the centre.

The service had enough suitable equipment to help them to safely care for patients. There was an effective system to ensure that repairs to broken equipment were carried out quickly so that patients did not experience delays to treatment. Servicing and maintenance of premises and equipment was carried out using a planned preventative maintenance programme. We checked the service dates for all equipment and found them to be within their service date.

Resuscitation equipment was on a purpose-built trolley and was visibly clean. Single-use items were sealed and in date. Resuscitation equipment had been checked daily and an up-to-date checklist confirmed all equipment was ready for use.

The arrangements for managing waste and clinical specimens kept people safe and staff adhered to the best available techniques (BAT) in relation to the accumulation and disposal of waste in line with the Environment Agency Environmental Permitting Regulations 2010 (EPR10). This included classification, segregation, storage, labelling, handling and disposal of waste. Staff maintained a contemporaneous record of patient injections to calculate the total annual waste for monitoring by the Environment Agency. Clinical waste disposal was provided through a service level agreement. Clinical waste and non-clinical waste were correctly segregated and collected separately. Clinical waste audits were completed monthly and showed 100% compliance with the services procedures.

An up to date fire evacuation plan was in place and all staff completed annual training. The service was provided over two levels and an evacuation chair was in situ to help people with reduced mobility evacuate from the first floor. Staff had completed practical training in the use of this equipment.

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A maintenance plan ensured clinical equipment was serviced in line with manufacturer guidelines, with routine checks scheduled six months in advance. The manager arranged such checks to have minimal impact on patients whilst maintaining safety and serviceability.

Staff did not always manage sharps in line with the Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 and waste in line with Department of Health and Social Care national guidance on the management of healthcare waste. For example, the sharps bin in the CT scanning room was not fully labelled with a date of first use. Staff assured us this was not usual practice and the box had recently been delivered and not yet used.

The reception area and all clinic rooms were fitted with panic alarms for staff to get help rapidly. The manager said it was very rare this system needed to be used but it was maintained and tested regularly to provide staff with a safe working environment.

The manager carried out a quarterly health, safety, and environment checklist in line with the provider's standards. We looked at audits for the previous 12 months and found evidence of good practice and effective action to achieve improvements. For example, an audit in January 2021 found 95% compliance, with a need for staff to ensure only approved waste products were disposed of in sharps bins. The auditor communicated this to staff and the following audits showed full compliance.

Assessing and responding to patient risk

Staff identified, responded to and removed or minimised risks to patients. Staff identified and quickly acted upon patients at risk of deterioration.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. The centre used a "pause and check" system in line with best practice guidance from the Society and College of Radiographers. Pause and check consisted of a system of three-point demographic checks to correctly identify the patient, as well as checking with the site or side of the patient's body that was to have images taken and the existence of any previous imaging the patient had received. Staff audited the completion of pause and check documentation on a monthly basis. Between August 2021 and October 2021, staff carried out 100% of expected pause and check components during a scan. The audit found room for improvement in documentation, with 93% of records including a staff signature to confirm the use of pause and check.

Safety signs were posted in appropriate locations, including at the entrance to the MRI waiting room. Signs reflected national standards and provided information on the safety risks presented in the area and checks for patients to ensure they were not at risk. Staff supplemented this safety system by ensuring each patient and chaperone completed a safety questionnaire before being able to enter the area. Staff audited this process and found 96% of safety questionnaires were fully completed between August 2021 and October 2021.

Staff knew about and dealt with any specific risk issues. Radiographers told us how any unexpected or significant findings from image reports were escalated to the treating consultant. Staff would contact the referrer by telephone and follow this up with an urgent report.

Staff knew how to respond promptly to a sudden deterioration in a patient's health. This was sometimes possible when a patient had a reaction to the contrast used for some types of scan. All radiographers were trained in immediate life support (ILS) and other staff maintained certification in basic life support (BLS). Staff completed simulated emergency

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training and followed the provider's up to date policy in such events, including calling 999 immediately. Simulated training included a six monthly scenario of a patient having a cardiac arrest whilst in the MRI scanner. An emergency trolley was located adjacent to the MRI scanner and contained equipment such as an automatic external defibrillator, oxygen, and equipment comtable for use in an MRI area.

Staff followed risk management processes when patients were injected with contrast. They were required to wait for 15 minutes with the cannula in situ after the injection to ensure there would be no adverse reaction.

Staff used an urgent findings escalation standard operating procedure and pathway to ensure patients with immediate needs received the most appropriate care. The pathway involved a call to the referring clinician to review diagnostic findings.

The senior team implemented safety measures for patients who had an infectious condition such as COVID-19. Staff would not carry out scans on patients until they were confirmed negative. If a referring doctor requested an urgent scan for a patient who was known to be COVID-19 positive, the radiologist liaised with them to assess the level of risk.

Staff arranged chaperones for patients on request. This could be arranged in advance or at the time of the scan. All gynaecological scans and colon CTs had a chaperone present as a matter of good practice reflective of the intimacy of the scans.

The provider had a rapid alert system to communicate safety updates to staff. The manager was responsible for these and a plan was in place to ensure another manager acted on alerts in their absence. Staff demonstrated good knowledge of recent alerts, such as a national update on CT room safety and an example of a failure to escalate an MRI finding. The manager used safety alerts to ensure staff maintained up to date knowledge. For example, following the MRI alert they prepared a quiz to test staff understanding of the criteria for urgent escalation.

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. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction.

The manager described a stable, committed team with some staff holding over 11 years of service. The service had enough clinical and support staff to keep patients safe. The service had five whole time equivalent (WTE) radiographers and a bank radiographer who provided additional capacity at weekends for patients referred from NHS services. A radiologist and other clinicians, such as a cardiologist, provided planned clinics.

A radiologist was always on site when contrast scans were in operation.

All appointments were pre-booked, and the manager planned staffing levels in advance. The manager carried out risk assessments for staff to work longer shifts during persistent, exceptional demand on the service. The provider's central staffing team arranged cover from other clinics in their network to mitigate staff absence. The service did not use agency staff.

The service had enough medical staff to keep patients safe. The service had radiologists on site who rotated based on the needs of the service. The radiologists provided reporting services as self-employed consultants under practising privileges. We saw evidence that all medical staff had valid professional registrations, medical indemnity insurance, completed mandatory training and appraisals.

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The service maintained a record of radiologist appraisals and revalidation.

The provider had a centrally-managed recruitment pathway that included procedures to ensure relevant recruitment checks were completed. These included a disclosure and barring service (DBS) check; occupational health clearance, references and qualification and professional registration checks. New recruits did not begin work without a DBS check in place.

The service had an up-to-date chaperone policy to reflect the changes made during the pandemic.

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 notes were comprehensive, and all staff could access them easily. Staff used secure electronic patient records to record patient's diagnostic needs.

Records were stored securely. All patient's data, medical records and scan results were documented via the centre's secure patient electronic record system.

The service received patient referrals through a secure email, online booking form, or telephone call from the referring consultant or hospital.

The centre provided referrers with encrypted electronic diagnostic imaging reports.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff stored and managed medicines and prescribing documents in line with the provider's policy. The medicines cupboards we inspected were locked, secure and all stock was within expiry dates. There were no controlled drugs (CDs) kept or administered.

Contrast media was stored in a secure area with restricted access. The contrast media was warmed before use in line with best practice. In rare cases contrast media can cause kidney damage. We saw records which showed there was a contrast checklist and point of care testing to assess a patient's risk in using the contrast agents.

Staff carried out a stock check of contrast media every week and audited expiry dates monthly.

Radiographers were authorised to work under patient group directions (PGDs) to administer contrast media used during MRI scans. PGDs showed the name of the radiographers and the medicines they were competent to use. Contrast used in CT scans was administered by radiologists under prescribing rules.

Staff used Patient Group Directions (PGDs) to administer contrast agents, intravenous injections and the administration of oxygen. PGDs were up to date and all staff who worked in the service had signed them.

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The service completed a quarterly medicines management audit. Records showed the service achieved 100%. The audit included all aspects of safe medicines management including temperature checks of storage areas and providing patients with printed information on the medicines they had received during a scan.

Allergies were clearly documented on referral forms and on the electronic patient records. Allergies were verbally checked during the diagnostic imaging safety checklist.

Some patients attended the clinic with diazepam prescribed by their GP. In such cases, staff asked the patient to attend one hour early and take their medicine on site. Staff monitored the patient's blood oxygen saturation level (SATS) during this period to ensure the planned scan could be carried out safely.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. 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. The service used an electronic incident reporting system and all staff we spoke with were familiar with how to report incidents. Incident reporting training was included in the staff induction programme, which all staff completed when they commenced their employment.

Staff said there was a good reporting culture and that they were encouraged to report 'near miss' situations. A medical physics expert was available for advice.

Staff raised concerns and reported incidents and near misses in line with the service's policy. We checked the incidents log and found incidents were reported and investigated in a timely manner.

The service had no never events, serious incidents or IR(ME)R incidents reported in the last 12 months. The manager audited incidents to identified trends, themes, and opportunities for learning. Between October 2020 and September 2021, staff reported 201 incidents. There were no incidents with harm to patients in this period and we saw consistently good standards of incident investigation and resolution.

The manager had oversight of this process and ensured each incident resulted in clear learning. One incident occurred when a radiographer had not escalated an urgent finding in a timely manner. The manager provided additional training, supervision, and competency checks with the individual involved. No harm occurred to the patient involved and an opportunity to ensure radiographers improved confidence in decision-making was identified.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

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Are Diagnostic imaging effective?

Inspected but not rated 

We do not currently rate effective for diagnostic imaging.

Evidence-based care and treatment

The service provided care and procedures based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff delivered care and treatment in line with legislation, national standards and evidence-based guidance, including from the National Institute for Health and Care Excellence (NICE), the Royal College of Radiologists, and the College of Radiographers.

Staff followed the 10 days rule for performing scans with ionising radiation on patients who were of childbearing age. This was international guidance maintained in the UK by the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) and limited such scans to the first 10 days of the menstrual cycle.

The service's policies and procedures were subject to review by the radiation protection advisor (RPA). The annual RPA audit against the Ionising Radiation (Medical Exposure) Regulations 2017 IR(ME)R had been completed in June 2021. The audit found the service was fully compliant with the current regulations, standards and reference guidance relating to the use of ionising radiation in diagnostic imaging.

Employers procedures were in date and due for review in late 2021.

To ensure safe radiation doses, the service applied the Public Health England guidance on National Diagnostic Reference Levels (NDRLs) when setting their local dose monitoring diagnostic reference levels (LDRLs). The LDRLs used were based on the national levels for both children and adults. Staff had updated the local DRLs with lower dose readings in October 2021. A magnetic resonance safety expert (MRSE) led dose optimisation and met with the provider-level safety team quarterly to review results and opportunities for improvement.

The manager led a monthly audit cycle that was planned 12 months in advance and included 12 standard audits. Additional audits were implemented on an ad-hoc basis if needed to address areas of performance.

An external specialist teleradiology service reviewed a sample of scan reports on a monthly basis as part of the provider's system to ensure high standards of clinical practice. Auditors were radiologists with General Medical Council (GMC) registration holding the Fellow of the Royal College of Radiologists status.

Audit results demonstrated consistently good standards of practice. We looked at the results of scan audits between September 2020 and August 2021 and found a highly effective system of ensuring good clinical practice. During this period, 755 scans were audited with a 96% accuracy rate. Where the auditor identified a clinical disagreement, they

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noted a low likelihood of harm to patients. Feedback was detailed and the image service manager met with staff to discuss the results and opportunities for improvement. One audited scan indicated a missed concern for escalation. The auditor carried out a root cause analysis and worked with the reporting radiologist to identify causation and implemented peer review processes to avoid future recurrence. This reflected national best practice.

An independent specialist audited the quality of scan images on a rolling basis. Between May 2021 and September 2021, an audit of 25 images found consistently high standards of scan image quality with no area for improvement or reassessment.

Nutrition and hydration

Staff made sure patients did not fast for too long before diagnostic procedures. Staff took into account patients' individual needs where food or drink were necessary for the procedure.

The nature of the service meant food and drink provision was unnecessary for effective care. However, water, hot drinks, and snacks were available in waiting areas.

Staff offered diabetic patients an early appointment in the morning or straight after lunch to help them manage safe blood sugar levels.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

Staff advised patients in advance to take any prescribed pain medicine before they attended the clinic.

Diagnostic imaging patients did not routinely require pain relief. However, staff described how they would offer support to patients who reported being in pain by referring them to their GP to obtain oral sedation.

Staff managed pain medicine in line with Royal College of Radiologists (RCR) guidance. Patients attended with their own pain medicine prescribed by the consultant leading their care. Staff in the scanning clinic monitored pain and ensured patients were comfortable. No additional pain medicine was stored in the clinic and if a patient could not tolerate a scan, the procedure was cancelled, and the patient referred back to their medical team.

Patient outcomes

Staff monitored the effectiveness of care. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. Outcomes for patients were positive, consistent and met expectations, such as national standards. The service completed audits of report quality, scan room warning lights and signs, personal protective equipment, and imaging health and safety checklist. Results showed the service performed consistently to a high standard.

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Managers shared and made sure staff understood information from the audits. Records showed that staff discussed the outcome of the image quality audits. An audit of report writing times from January to September 2021 found 97% of reports were completed within 48 hours.

The manager monitored clinical indicators to ensure patients received the right onward referral and care. The manager identified a trend of missing information from GP referrals that meant patients presented for scans with comorbidities that the clinical team needed to be aware of to provide effective care. In each case clinical staff carried out safe scans and referred patients to hospital for further treatment.

Between October 2020 and September 2021, staff reported 80% of scans within five days. This was an average figure and reflected monthly variations between 97% and 60%. Extended reporting times in some months reflected the most restrictive times during the COVID-19 pandemic when the service provided additional capacity to NHS services that had ceased. Staff rejected 0.9% of referrals because they did not meet safe criteria. In such cases, the service returned the referral within 24 hours.

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. All health care staff were registered with their appropriate professional bodies and maintained up to date training and competencies in their areas of responsibility. For example, radiographer assistants were trained in DEXA scans and we saw evidence of up to date competencies and radiographers were trained in CT colonoscopy. A radiographer carried out CT coronary angiogram in the presence of a cardiologist and radiographers were trained to carry out pre-scan blood tests for creatinine.

All clinical staff were registered with a professional body, such as the Health and Care Professions Council (HCPC) for radiographers and sonographers. This included bank staff.

The service ensured it received evidence annually from medical practitioners about appraisals and registrations as part of their practising privileges.

Managers supported staff to develop through a supervision and appraisal programme that included structured one-to-one continuing professional development sessions every quarter. The manager had maintained supervisions and appraisals despite the pressures on the service during the pandemic. At the time of our inspection, 100% of staff were up to date with appraisals. Staff said they had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. A number of staff were undertaking university study and said the senior team was supportive of this.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

The provider required staff trained in cannulation to carry out annual reflective self-assessments on their practice, in line with a peripheral intravenous cannulation policy. This helped staff to identify opportunities for improvement. We

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reviewed a sample of 19 reflective logs, totalling 90 cannulation instances. In each case staff noted good practice or areas for training or improvement. A senior radiographer carried out observations of cannula removal as part of a wider safety audit. We looked at 10 observational audit examples and found consistent practice in line with the provider's standards.

Multidisciplinary working

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

Staff worked closely with referrers to enable patients to have a prompt diagnosis and treatment pathway. If they identified concerns from scans, they escalated them to the referrer.

Staff we spoke with told us they had good working relationships with consultants. This ensured that staff could share necessary information about the patients and provide holistic care.

The service implemented a daily operational safety huddle which was multidisciplinary. It provided a forum for staff to communicate relevant issues and escalate any concerns for immediate action.

Seven-day services

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

The service operated seven days a week from 7am to 9pm and was consistently full to capacity.

Referrals were prioritised by clinical urgency, including appointments at short notice, and in line with contractual requirements of the referring organisations.

Staff said if an urgent referral was made the centre would assess appointments and prioritise patients according to their clinical needs and requirements of the referring consultant. Staff said patients could speak to the consultants to discuss any concerns.

Health promotion

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

Health promotion material signposting patients to specialist services was readily available in the clinic. Material was relevant to the services provided such as guidance on accessing National Osteoporosis Society support.

The provider actively promoted good health and lifestyle choices on their website and social media channels. They promoted national campaigns and signposted patients to relevant organisations. For example, the provider had taken part in the International Men's Health Awareness Week in 2021 and provided information on health promotion work from the Mental Health Foundation. Staff selected campaigns and organisations that were relevant to the health needs of patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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Staff supported patients to make informed decisions about their care. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Patients referred to the service were pre-assessed for mental capacity before they came to the clinic. However, staff had access to assessment tools and senior clinical support if they felt a patient did not have capacity to consent or make a decision.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. An audit of the imaging consent procedure from October 2020 to September 2021 showed 97.5% compliance.

Staff made sure patients consented to treatment based on all the information available. Staff explained how they gained consent for a scan. Patients we spoke with confirmed they had been asked for, and had given, their consent for the procedure they had attended for.

We saw that staff clearly recorded consent in the patients' records. The service audited consent practices on a rolling basis by checking scan documentation for evidence of patients' consent confirmed by the radiographers signature. Between December 2020 and August 2021 an audit of 31 records found 100% compliance of patient signed consent, with two records unable to be assessed due to missing scan pages. Six records had no section for the radiographer to sign due to the type of template used. The imagine service manager met with staff to ensure they used the correct documentation.

All clinical staff received and kept up to date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). At the time of our inspection the team was 100% compliant with this requirement. Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff asked each patient undergoing an MRI to complete a mental capacity screening record. Staff did not carry out scans if they did not have a clear understanding and evidence of consent or the arrangements of a power of attorney (PoA). Where PoA documentation was expected but missing, staff contacted the patient's GP to obtain proxy consent.

Are Diagnostic imaging caring?

Our rating of caring stayed the same. 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. Patients we spoke with told us they found the team was professional, friendly, and efficient.

Diagnostic imaging

The results of the patient satisfaction survey show the service was consistently rated high for compassionate care. From December 2020 to September 2021 100% of patients said they were treated with care and compassion.

Patients said staff treated them well and with kindness and were helpful and reassuring.

Emotional support

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

Staff understood the impact that patients care, treatment and condition had on the patient's well-being. Staff we spoke with stressed the importance of treating patients as individuals with different needs. The service had dedicated space for challenging or difficult conversations.

Staff gave patients and those close to them support and advice when they needed it. A patient who was afraid of needles explained how staff reassured them and made them feel comfortable during the procedure. This reduced the patient's anxiety, fear, and made them feel calm. The patient said the radiographer's patience and kindness helped them to cope with a difficult examination.

The service performed consistently well in privacy and dignity measures. A spot check audit of staff practice found 100% compliance with provider standards. This included use of appropriate body language, identifying each patient's preferred way of being addressed, the offer of private space for confidential discussions and evidence of staff identifying the acceptability of personal contact with each patient.

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 diagnostic procedures.

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary. Patients said staff explained the procedure, checked what diagnostic procedure they were having and checked their identity.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff encouraged each patient to complete a feedback form online following their appointment.

Patients gave positive feedback about the service. From the December 2020 to September 2021 patient satisfaction survey 98% of patients said that treatment was explained to them before any care was provided and 100% said they would be happy to return for future appointments.

The service carried out continuous assessment of patient feedback using the NHS Friends and Family Test (FFT) as a structure. The most recent results were analysed in August 2021 and demonstrated a 98% recommendation rate. In the previous year, monthly results were consistently about 96%. Access to the survey was straightforward and patients could complete this using an on-site electronic tablet.

Diagnostic imaging

Posters were displayed in waiting areas to give examples of how staff would wear new standards of personal protective equipment (PPE). Staff said this was designed to reduce patient's anxiety when they encountered staff wearing PPE such as goggles or masks and helped to manage patient's expectations around safety.

Are Diagnostic imaging responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of people who used the service.

The service planned and provided care in a way that met the needs of people who use the service. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the people who used the service. The service provided planned diagnostic treatment for patients at their convenience. Appointments could be coordinated between the referring hospital and the clinic to make the most of care pathways.

Patients referred within clinical commissioning group (CCG) contracts were seen within four to six weeks. NHS patients referred within a cancer pathway were seen within seven days in line with the national standard. In the previous 12 months the service was 100% compliant with this standard and reported no breaches.

Managers monitored and acted to minimise missed appointments. Missed appointments were recorded electronically and patients contacted to rebook appointments. The outcome of each contact was recorded. Appointments cancelled by the service amounted to 1.3% of total visits.

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. They coordinated care with other services and providers.

Managers made sure staff, patients, and carers could access interpreters or signers when needed. Interpreters were arranged in advance either in person or by phone. Where staff were unaware of a language need or they felt a patient could not adequately understand the procedure due to language needs, they used an on-demand phone interpretation service. The provider website included safety information and forms in Arabic, Turkish, Urdu and Bengali, the languages most often used by patients.

The clinic was fully step-free from the street to all clinical areas. It had toilets that could be accessed by people using a wheelchair and the reception desk was fitted with a hearing loop.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service had resources for patients with learning difficulties such as a communication resource book with easy read formats, Makaton signs, and visual symbols.

Diagnostic imaging

Staff planned care for patients living with learning difficulties or dementia in advance. This enabled them to modify investigations and assist with planning for the patient's appointment. All staff undertook training in communicating with patients living with learning difficulties or dementia and offered patients the opportunity to visit the clinic and acclimatise themselves to the environment and equipment. This reflected good practice and helped to reduce patient's anxieties.

Patients had access to a private locker to store their personal belongings during scans. There was a comfortable seating area, cold water fountain, drinks machine for making hot drinks and toilet facilities for patients and visitors.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to test and from test to results were in line with national standards.

Patients were referred by GPs and occasionally by three local NHS trusts. The senior team said there had been a significant increase in CT referrals and opening hours and capacity had been extended to accommodate this. In addition the service had recruited a bank sonographer to carry out scans for NHS-referred patients during weekends. This reflected the adaptability of the service to demand.

The service provided up to 30 DEXA scans per week, with a maximum of six per day.

Staff demonstrated attention to detail when ensuring the service was fully accessible for patients. For example, if the lift was out of service and patients with mobility needs were booked into a clinic on the first floor, staff proactively contacted them and made alternative arrangements.

The team had improved the availability of early afternoon appointments for elderly patients following feedback that early or late appointments were unsuitable.

The service offered self-referrals following a triage process by a radiographer or radiologist to ensure they were appropriate. Systems were in place to ensure appointments were safe. For example, non-medical referrals were not accepted.

Staff called each patient the day before their appointment to ensure it was still convenient and they planned to attend. This helped to reduce wasted appointments from non-attendance and meant staff could identify any additional needs for which they needed to prepare. The service maintained a did not attend (DNA) rate of 4% and the manager monitored local conditions that might impact this such as COVID-19 infection rates and fuel shortages. Administration staff called each patient who did not attend a booked appointment. The imaging services manager reported figures weekly to NHS trusts where their referred patients had not attended.

Staff scheduled scans within agreed key performance indicators defined by the referring organisation, the type of scan required, and the urgency of the scan. The service audited performance against such measures. Between October 2020 and September 2021, the clinic performed consistently well. Of NHS and private healthcare referrals for MRI, DEXA, CT and ultrasound scans, 100% of patients were seen within planned times.

Learning from complaints and concerns

Diagnostic imaging

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The provider had a complaints policy and a central quality and complaints team to support the local clinic manager. The policy outlined how complaints were acknowledged, investigated and resolved and included guidance for patients if they were unhappy with the outcome. The provider's standard was to acknowledge a complaint within three working days and to provide a full response within 20 working days.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas and the website.

Managers shared feedback from complaints via emails and meetings and learning was used to improve the patient's experience. We spoke with staff who were able to identify how to support a complaint, be it informal or formal, and how it was escalated and managed by senior managers. Staff could give examples of how they used patient feedback to improve the service. For example, changes were made to strengthen the pre-assessment process.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. There had been six complaints in the previous 12 months. Two complaints related to the information provided after a scan was sent to the patients' GPs. In each case the radiologist reviewed the scans, produced an addendum with additional information and contacted the patient and their GP.

The manager demonstrated how they made improvements to the service based on the outcomes of complaints. For example, two complaints related to incorrect arrival information on printed appointment letters received by the NHS Choose and Book system. The imaging services manager liaised with referring GPs to resolve the issue and ensure information was accurate. This demonstrated the senior team's proactive approach to engaging with partners where the cause of a complaint was shared. For example, where a referring NHS trust received a complaint, their complaints manager liaised with this service to provide a joint response.

The governance lead maintained oversight of all formal complaints until they were resolved. They discussed the progress of each during weekly service manager meetings with input from senior imaging staff.

Are Diagnostic imaging well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the 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. They supported staff to develop their skills and take on more senior roles.

Diagnostic imaging

The imaging services manager maintained overall responsibility for the service. They were based in the clinic Monday to Friday from 9am to 5pm. During weekends the provider had an on-call service for escalation by the local team. This ensured staff had access to a senior team for confirmation of difficult scans and for support with incidents or safeguarding scans. The provider's regional head of operations was the first line of support for staff who needed senior input when the service manager was not on site.

The imaging service manager was deeply committed to patient care and the success of the service. They demonstrated a clear understanding of how the service helped to improve capacity and patient outcomes across the local health economy. Accredited by the Chartered Management Institute, the manager had a continuing professional development plan appropriate to the needs of their team and patients.

An imaging services manager led the service on a day to day basis with support from superintendents, who supervised each modality.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The provider had a national vision and strategy focused on excellent patient care and sustainability. The manager and team demonstrated a good understanding of this and how it applied to their work in this specific clinic.

The manager introduced the provider's vision and strategy at the point of interview to test how an individual's experiences and work ethic reflected these. They considered examples given by new applicants to better understand how they interpreted the organisation's corporate values.

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, their families and staff could raise concerns without fear.

Staff we spoke with were proud of the work that they carried out. They enjoyed working at the centre; they were enthusiastic about the care and services they provided for patients. They described the centre as a good place to work.

Staff said they felt that their concerns were addressed, and they could easily talk with the manager and wider senior team. Staff reported that there was a no blame culture that encouraged learning.

Patients told us they were very happy with the services and did not have any concerns to raise. They felt they were able to raise any concerns with the team without fearing their care would be affected.

Governance

Diagnostic imaging

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The clinical services manager attended weekly complaints, incidents, litigation, and compliments (CLIC) meetings with the governance team when required to discuss any recent incidents or complaints. The governance team reviewed all incidents, complaints, national updates, safety alerts, and patient feedback on a weekly basis. The team used CLIC meetings to review any pressures on the service and was a structured forum in which to solve problems and share learning.

The service had effective systems, such as audits and risk assessments, to monitor the quality and safety of the service.

Staff used a series of meetings to monitor the service, including staffing and performance. This included a service leads meeting, administrative staff meeting, senior team meeting and general staff meeting. Staff attended meetings consistently and we saw evidence of a positive impact on working conditions, working practices, and patient experience as a result.

Staff carried out daily quality assurance checks on the MRI scanner and weekly quality assurance checks on the CT scanner. We saw these were completed consistently with no gaps. A magnetic resonance safety expert (MRSE) provided oversight for the clinic and attended quarterly safety meetings.

The manager prepared quarterly quality reports for the Clinical Commissioning Group (CCG). Prior to the pandemic the service had participated in the Commissioning for Quality and Innovation (CQUIN) programme to set extra quality improvement goals alongside other local providers. This reflected good practice and resulted in improved patient care, such as the implementation of a new electronic records system. The programme had been suspended regionally during the COVID-19 pandemic. The manager said the service was preparing to resume CQUINs on approval from the CCG.

The clinical quality subcommittee met quarterly to review service quality measures, incidents, complaints, shared learning, and patient feedback. We looked at the minutes of the previous three meetings. We saw meetings were consistently well attended by an appropriate range and seniority of staff who took action to mitigate risks and trends. For example, in July 2021 the subcommittee highlighted increasing staff sickness across the organisation and a concurrent shortfall in some consumables from suppliers. The group implemented an action plan to address both issues to ensure service sustainability and safety.

The radiation protection committee met quarterly as part of safety compliance processes. We reviewed the minutes of the most recent meeting and found the well-attended group discussed relevant safety factors. These included changes to Health and Safety Executive (HSE) guidance on consent processes, changes to national ionising radiation practices, adverse event reviews, legislation changes, regulatory changes, and updates to ARSAC.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified 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.

Diagnostic imaging

The senior team used a risk register to manage risks to the service. The key risk to the service related to ageing DEXA, MRI, and CT scanners, some of which were approaching the end of their useful life. We told the provider at our last inspection in September 2018 that they should implement a capital replacement programme. At this inspection we found the director of capital projects and mobilisation was leading a five year process to replace the equipment by the end of 2022. However, no firm conclusion had been reached despite the provider noting that extensive discussions had taken place over the previous 12 months. Risk registers supplied by the provider did not document this risk. The only local risk related to cladding on the building, which had been found to be unsafe and present an elevated fire risk. The manager had liaised with the local fire service who had carried out a risk assessment and deemed the service safe to operate with a modified fire safety and evacuation plan.

A new risk had been identified from the CT scanner, which exposed people to slightly higher doses of radiation due to its age. The provider's senior team was in the process of reviewing the risk to identify appropriate mitigation and ensure patients were as safe as possible.

A mobile planning team was on call at all times the service was in operation. Local staff escalated equipment failures or concerns to the team, who arranged for a rapid response from maintenance staff. Where repairs were not possible, the mobile team identified the nearest alternative facility for patients to be redirected or for mobile equipment to be set up.

The radiologist attended monthly radiology events and learning meetings (REALM) in the NHS trust that referred most patients to this service. The attending team carried out monthly peer review audits.

During the COVID-19 pandemic the service receive several patients for emergency scans sent by GPs instead of to hospital accident and emergency departments. This presented a significant risk of delayed diagnostics and the manager worked with the CCG to stop the practice.

The service demonstrated highly effective contingency plans during service disruption. When a scanner failed and could not be repaired quickly, the mobile scanning team and manager arranged for a mobile scanner to be installed on the site of a local hospital. This included an independent power generator and toilets and was up and running within 24 hours. The clinic team called all patients who would be impacted and arranged for their scans to take place at the alternative site.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service had an up to date data protection policy. The data protection officer was responsible for application of the policy and the risk and governance sub-committee ratified each update. Staff were trained to handle data according to the policy, which was compliant with the General Data Protection Regulations 2016 (GDPR) and Data Protection Act 2018.

Diagnostic imaging

Prior to changes leading from service restrictions during the pandemic, the manager was working with their IT team and the CCG to implement internal access to the NHS Choose and Book system. This would enable more efficient data management and enable the clinic to offer a more responsive service. The programme had been suspended temporarily and the manager said they would restart it as soon as the CCG approved the resumption of CQUINs, which would provide a framework for the system.

Staff checked referral summaries to ensure patients were within their contractual remit. Where patients were outside of this, the manager liaised with the referring GP to resolve the situation.

Engagement

Leaders and staff actively and openly engaged with patients and staff, to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff spoke positively about working for the provider and about support from managers. There was a clear focus from the senior team on supporting staff development and a number of staff were undertaking advanced training. This included one member of the team who was completing a postgraduate MRI programme, another who was undergoing a radiographer apprenticeship and staff who were completing cannulation competencies. Staff said they received regular wellbeing updates. For example, information on maintaining mental health during the COVID-19 pandemic.

The manager recognised the impact of additional pressures on the service on staff mental wellbeing. The provided on-demand support and encouraged staff to use the provider's external arrangement with a counselling service.

The service demonstrated a strong track record of engagement with staff to ensure they could work effectively and achieve a good work-life balance. For example, the manager had worked with specialist staff to implement a new policy for staff experiencing the menopause. This enabled them to adapt their working hours in line with their health needs, which significantly reduced the stress and emotional impact they felt from trying to manage rigid hours.

The manager shared feedback from patients with staff to help them understand what people liked about the service. Recent feedback included, "Very high quality service. Very pleased", and, "Very nice and informative staff. Felt good."

The imaging services manager prepared a monthly 'you said, we did' poster for staff and patients based on feedback from a variety of sources. Recent changes included the provision of more comfortable and dignified patient gowns and an improved PACS system.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service participated in the national Oxford Risk Factors and Non-Invasive Imaging Study (ORFAN) to drive innovation in scanning quality for patients living with cardiovascular conditions.