Yorkshire Clinic Imaging Centre

Quality Report

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

Ratings

Overall rating for this location	**Good**
Are services safe?	**Requires improvement**
Are services effective?	**Not sufficient evidence to rate**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Overall summary

Yorkshire Clinic Imaging Centre is part of Alliance Medical Limited group. Yorkshire Clinic Imaging Centre is situated within an independent hospital for which it provides diagnostic imaging services. This includes Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) services

The service also provides a CT colonography service with rectal cannulation undertaken by a Gastrointestinal (GI) consultant radiologist. The service also used radiographers to complete this service. The radiographers were trained to complete this and worked under the supervision of GI consultant radiologists.

Summary of findings

Yorkshire Clinic Imaging Centre's diagnostic imaging services were inspected using our comprehensive inspection methodology. We carried out an unannounced visit to the hospital on 8 January 2019 and telephone interviews with staff on the 17 January and 11 February 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 rated this service as **Good** overall.

We found good practice in relation to diagnostic imaging:

- Managers had the right skills and abilities to run the service and staff described a positive culture where managers, staff and the multi-disciplinary team worked well together. The service ensured staff were competent with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Managers appraised staff's work performance as a means of development.
- The service had suitable premises and equipment and looked after them well. Equipment and premises were visibly clean, and staff used control measures to prevent the spread of infection.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. Patients records were clear, up-to-date and available to all staff providing care.
- The service systematically improved service quality and safeguarded high standards of care. Patient safety incidents were well managed, and staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Staff of different kinds worked together as a team to benefit patients.
- The service treated concerns and complaints seriously, investigated them, learned lessons from the results, and shared these with all staff.
- Staff cared for patients with compassion, provided emotional support to minimise their distress and involved patients and those close to them in decisions about their care and treatment. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Policies and procedures were implemented when a patient could not give consent.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The service planned and provided services that met and took account of the individual needs of local people. Care and treatment was based on national guidance and evidence of its effectiveness and managers checked that staff followed this guidance.
- People could access the service when they needed it. Waiting times from referral to scan were in line with good practice.

However, we also found the following issues that the service provider needs to improve:

- Documentation of daily checks of the warming equipment had not taken place.
- Authorising signatures for patient group directions (PGD's) were not present against the PGDs.
- The Alliance Medical Limited medicines management policy (v2.4) was overdue for review. However, the provider has recently informed us that a dual policy agreement existed with the local hospital healthcare provider. The service worked to the healthcare providers medicines management policy which was reviewed in October 2018.

Summary of findings

- The keys to the medicine's cupboard were kept in the medicine cupboard door in the control room. However, access to the control room was not restricted which meant unauthorised access to medicines could occur.
- Checks and administration of contrasts to patients were not always completed by two trained staff

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals (Hospitals)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	We rated this service as good overall with ratings of good for caring, responsive and well-led and requires improvement for safe. CQC does not rate effective for diagnostic imaging services. There were areas of good practice and a few areas the provider should improve.

Summary of findings

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Summary of this inspection

Background to Yorkshire Clinic Imaging Centre

Yorkshire Clinic Imaging Centre is part of Alliance Medical Limited group. Yorkshire Clinic Imaging Centre is situated within an independent hospital for which it provides diagnostic imaging services. This includes Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) services

The service also provides a CT colonography service with rectal cannulation undertaken by a Gastrointestinal (GI) consultant radiologist. The service also used radiographers to complete this service. The radiographers were trained to complete this and worked under the supervision of GI consultant radiologists. The radiographer's responsibilities included injection of contrasts through patient group directions.

Yorkshire Clinic Imaging Centre's patient mix has changed significantly. In 1999, private patients only were scanned at the clinic. In 2018, 20% of patients were privately funded whilst the remaining 80% of patients were NHS funded.

Yorkshire Clinic Imaging Centres registered manager had been in post since 14 March 2016**.** The regulated activities at this location included: Treatment of disease, disorder or injury and diagnostic and screening procedures.

We carried out an unannounced visit to the Yorkshire Clinic Imaging Centre on 8 January 2019 and held telephone interviews with staff on the 17 January and 11 February 2019.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one CQC inspector, and a specialist advisor with expertise in diagnostic imaging.

Information about Yorkshire Clinic Imaging Centre

Yorkshire Clinic Imaging Centres activity has increased. In 1999, there were approximately 120 patients in Magnetic Resonance Imaging (MRI) and 40 patients monthly in Computed Tomography (CT) scanned by two full time radiographers. By comparison, in July 2018, 525 MRI patients and 282 CT patients were scanned by a team of five radiographers.

Yorkshire Clinic Imaging Centre is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Diagnostic and screening procedures

During the inspection, we visited the diagnostic imaging centre which shared a reception area with radiology and physiotherapy.

We spoke with eight staff including radiographers, one radiologist and members of the management team. Two radiologists worked at the clinic under practising privileges.

We spoke with two patients and one parent. During our inspection, we reviewed two patients' records. The records review included one patient's set of completed paper assessment records and consent forms and one previous patient's electronic records which included completed risk documentation, consent and patient assessment documentation.

There were no special reviews or investigations of the Yorkshire Clinic Imaging Centre ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected previously,the most recent inspection took place on the 18 September 2013 where they met the five standards of quality and safety it was inspected against.

Summary of this inspection

Activity (1 January 2018 to 31 December 2018)

- In the reporting period 1 January 2018 to 31 December 2018 there were 9756-day case episodes of care recorded at the clinic; of these 80% were NHS-funded and 20% other funded.

Track record on safety

- Zero never events
- Zero serious incidents
- One IRMER / RR Incident – Classified Low Harm Incident which required a duty of candour notification.
- Zero serious injuries
- Zero incidences of healthcare acquired infections
- One complaint

Activity (15 August to 29 November 2018)

- Clinical incidents – Zero no harm, severe harm and death. There were six low harm and three moderate harm incidents.

Services accredited by a national body:

- Imaging Services Accreditation Scheme (ISAS) – July 2018, for renewal July 2021. There is an on-going cycle of re-assessments over four years
- ISO27001 - July 2018, for renewal July 2021
- Health & Social Care Information Centre Information Governance Toolkit

Services provided at the clinic under service level agreement:

- Clinical and or non-clinical waste removal
- Interpreting services
- Grounds Maintenance
- Laser protection service
- Laundry
- Maintenance of medical equipment
- RMO provision

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

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

- Patient group directions were not being used in line with legislation.
- Authorising signatures for patient group directions (PGD's) were not present against the PGDs.
- Medicines were not managed safely as contrasts once checked were given by a staff member who had not been involved in drawing up and checking the contrast agent.
- Medicines storage was not secure.
- Daily checks of the warming equipment were not documented. The Alliance Medical Limited medicines management policy (v2.4) was overdue for review. However, the provider recently informed us that a dual policy agreement existed with the local hospital healthcare provider. The service worked to the healthcare providers medicines management policy which was reviewed in October 2018.

However, we also found the following areas of good practice:

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The service had suitable premises and equipment and looked after them well. Equipment and premises were visibly clean, and staff used control measures to prevent the spread of infection.
- Staff learned from recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the team.

Are services effective?

Not sufficient evidence to rate

We do not currently rate effective for diagnostic imaging services. We found the following areas of positive practise:

- Staff of different kinds worked together as a team to benefit patients. The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to ensure staff followed guidance.
- The service made sure staff were competent for their roles and managers appraised staff's work performance to aid their development.

Summary of this inspection

- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care and followed the service policy and procedures when a patient could not give consent.

Are services caring?

Good

We rated caring as **Good** because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.

Are services responsive?

Good

We rated responsive as **Good** because:

- The service planned and provided services in a way that met the needs of local people and of the individual patient.
- People could access the service when they needed it. Waiting times from referral to scan were in line with good practice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Are services well-led?

Good

We rated well-led as **Good** because:

- The service had managers with the right skills and abilities to run the service and staff described a positive culture where they were supported by their managers.
- The service followed the Alliance Medical Limited values of collaboration, excellence, efficiency and learning and was committed to improving services by learning from when things went well or wrong and promoting training.
- The service improved service quality and safeguarded high standards of care through systems which identified risks, plans to eliminate or reduce risks, and were able to cope with both the expected and unexpected.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

Summary of this inspection

However, we also found the following issues that the service provider needs to improve:

- The Yorkshire Clinic Imaging Centre did not have a local strategy.
- Three moderate risks with a rating of 12 were identified on the local risk register. The report did not identify what actions or monitoring was in place to reduce the risks in these three areas.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Requires improvement	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Not rated	Good	Good	Good	Good

Notes

Good

Diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Requires improvement

We rated safe as **requires improvement.**

Mandatory training

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

Mandatory training programmes were completed yearly through an e-learning platform and 98% of staff had completed mandatory training sessions as of the 8 January 2019.

The mandatory training needs analysis showed the description of training, staff groups the training applied to, frequency and whether the training was online or face to face. Mandatory training included: manual handling, conflict resolution, infection prevention and control, fire, level two safeguarding adults and children training and complaints. Staff also completed one day practical immediate life support training sessions.

Safeguarding training statistics provided up to 8 January 2019 confirmed 100% of staff had completed level two adult safeguarding training. Staff told us training comprised of three safeguarding scenarios which included questions which the staff member responded to. Alliance Medical Limited provided adult and children's safeguarding training sessions at level one, two or three. The safeguarding lead had completed level three adults safeguarding 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.

The service had a designated safeguarding lead with appropriate training. Staff could also contact the independent hospital safeguarding lead for advice and support.

Guidance in the form of adult and children's safeguarding policies and procedures were available which outlined staff responsibilities and involvement of other professions such as the local authority and/or police. Guidance about female genital mutilation was included in the children's safeguarding policy (v1). We observed that the adults safeguarding policy (v3) made a brief reference to the wording female genital mutilation in the domestic abuse section of the policy. Staff we spoke with demonstrated a good understanding of safeguarding and what to do should they have any safeguarding concerns.

Managers made sure all staff had enhanced disclosure and barring service checks before they started their contracts, and these were reviewed every three years.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

There was a designated infection control lead for the service.

The unit was visibly clean and control measures such as hand gel, aprons and gloves were available. Hand

washing facilities were available, and staff were seen to have bare arms below their elbows. Cleaning schedules were displayed and were seen to be signed and dated when the task was completed.

The National Patient Safety Agency hand washing techniques poster 'Your 5 moments for hand hygiene at the point of care' was displayed throughout the unit which advised correct hand washing practises. Staff used hand gel between patients and hand gel was available for patient and visitor use in the main reception area and on entry to the unit.

The annual Infection Prevention and Control Report (July 2018) confirmed the outcomes of hand hygiene and insertion of peripheral vascular device (PVD) audits mean scores as 98%. The annual infection prevention and control (IPC) audit bench mark for 2017/18 was 80%. The unit was visited in August 2017 and achieved a score of 80%. The 2018/19 IPC benchmark was 90%. The Yorkshire Clinic Imaging Centre IPC audit results (dated 1 July 2018 to 31 December 2018) showed full compliance in every area and was rated as green.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

Security was maintained through restricted access arrangements. The main scanning department had keypad access from the main waiting area into the department waiting area.

Prior to new equipment introduction, staff received training specific to the equipment introduced, for example, pump injectors, scanners and the new blood pressure monitor.

Emergency buzzers were tested prior to every patient session. Diagnostic equipment maintenance checks were confirmed by the presence of stickers on equipment and checks logged against the maintenance log. Staff told us that when there were equipment issues they contacted the medical equipment engineer based at the independent hospital the service was based in.

A locked resuscitation trolley was in the main reception area and daily equipment checks were completed by the radiographers. Restocking of the trolley was undertaken by the independent hospital where the service was located through a service level agreement.

A warming drawer was used to heat the contrast agents used during identified scans. The warmer was checked daily, however, the checks were not documented. We observed each warmer drawer had an expiry date identified, 01/2023, 03/2023 and 06/2026 respectively.

The Magnetic Resonance Imaging (MRI) scanning room door had a Magnetom warning sign and a danger sign. A tape was pulled across the door to prevent entry.

Safety signs alerted people when the MRI or computed tomography (CT) rooms were in use. Controlled area x-ray signs outside of the scanner rooms were seen to light up when the rooms were in use. A radiation-controlled area sign and authorised persons sign was displayed on the CT scanner door.

The quality assurance checks for 2018 confirmed that both scanners were in working order.

Magnetic resonance imaging (MRI) quality assurance (QA) was completed quarterly by the manufacturers and we saw service documentation which confirmed quarterly maintenance checks had taken place; the last maintenance test took place on the 30 October 2018.

Staff told us scanning equipment was serviced three-monthly. The CT scanners' last survey took place on the 10 October 2018 and no recommendations were identified following this survey and the next planned preventative maintenance review was scheduled for 25 January 2019.

Weekly CT quality assurance took place. The CT quality assurance procedure (issued 12 September 2018) was reviewed annually at the Yorkshire Clinic Imaging Centre. We saw quality assurance checks completed for January 2019. When the checks were out of tolerance the engineers were contacted and the CT scanner not used until checks had been completed.

The Control of Substances Hazardous to Health (COSHH) folder contained individual COSHH assessment sheets. However, we noted that the review dates of the antimicrobial hand cleanser COSSH assessment sheet were dated within a day of each other. Initial date was 8 October 2018, followed by a review date of 9 October 2018. We raised this with managers at the end of the inspection and they confirmed they would investigate this.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

A radiation risk assessment was completed for the location.

Local rules were in place which staff familiarised themselves with prior to working in the unit. The name of the radiation protection supervisor was identified on the local rules; however, we saw no contact telephone number identified.

Females between the ages of 18 and 55 years were asked whether they were pregnant prior to investigations. Pregnancy checking procedures were in place and guidance in leaflet form advised patients to tell staff before they had their scan.

Prior to and entering the scan room we observed the radiographer checked they had the right patient and checks against the patient's documentation were made.

Specialised personal protective equipment was used by staff and carers. Lead aprons were used by a family member or carer if they stayed in the room. The hospitals x-ray department had last completed checks of lead aprons to screen for cracks in June 2017. Staff told us that lead apron checks should take place annually. Following the inspection, the provider confirmed that annual lead apron audits had taken place and were recorded in the department. However, the team said they saw no evidence of these audits having taken place in 2018.

Staff were monitored for radiation exposure. Radiation exposure was captured through film badges monitored through Public Health England. The film badge results were sent back to the Yorkshire Imaging Centre's registered manager who forwarded them onto the radiation protection adviser. Integrated governance and risk board minutes (March 2018 and September 2017) identified no concerns around film badge results. The annual radiation protection adviser report (10 October 2018) confirmed there had been no incidences of doses exceeding investigation levels.

The 'Patient Identification and Justification of Request Policy' (v5) identified how the checking process assured staff they had the correct patient and were giving the right treatment at the right time. The three-point check was used which included checks of patient name, date of birth and address. We saw 'stop and pause' checks were completed for each patient.

Risk assessment of the patient was via the 'patient safety consent questionnaire' which was completed by the patient. Safety questionnaires once completed were scanned onto the information technology system. Two patients were tracked through the scanning process and patient safety questionnaires were completed by the patient. We were also shown scanned copies of these safety questionnaires stored on the computer.

The radiologist completed the World Health Organisation (WHO) checklist for radiological interventions when invasive procedures were planned. Radiographers completed a safety form specific to the contrast used which we saw in use.

The service had a **'**Management of Medical Emergencies Policy and Procedure' (v4) which included advice on medical emergencies, the level of resuscitation training required and the need for completion of yearly resuscitation simulation training. Two unannounced resuscitation scenario tests took place annually. The documented outcomes of the unannounced resuscitation scenario dated 20 February 2018 identified some improvements in clinical practice were required, however, overall practise was satisfactory. An action plan was not identified following this resuscitation scenario.

In addition, staff told us that an anaphylaxis tray was kept in the CT scanning room; however, this was not locked away when the room was not in use.

Standard operating procedures (date issued: 9 August 2018) were identified for the unwell patient and visitor. These procedures were reviewed annually and were specific to Yorkshire Clinic Imaging Centre.

Staffing

The service had enough staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

The staffing model at the Yorkshire Clinic Imaging Centre identified the following staffing requirements.

4.10 Whole Time Equivalent (WTE) Radiographers

1.85 WTE Clinical Assistants

1 WTE Unit Manager

2.75WTE Admin

Staffing levels by staff type and number as of 8 January 2019 are shown below:

1WTE Unit Manager

0.8WTE Clinical Lead Radiographer

5.7WTE Senior Radiographer

1.3WTE Clinical Assistant

0.85WTE Clinical Assistant/Administrator

2.75WTE Administrator

'To ensure safe staffing levels and to establish the correct full-time equivalent staffing required a staffing calculator was used to work out the required staff to run two scanners. The 28-day staffing model for April 2018 showed that two radiographers were allocated to work all but four days. The Saturday shifts included two radiographers one of which was working an extra shift to make up a shortfall in their hours 36 hours / 40 hours per week. Shift patterns for radiographers were from 0700hours until 1800hours.

The minimum staffing levels per day when full lists were running was three radiographers and one clinical assistant. However, these staffing levels were reduced to two radiographers or two immediate life support trained staff members when one scanner was running.

When staffing pressures were identified the CT lists were reduced in advance to keep the service safe.

The service had two radiologists employed through the practicing privileges agreement. This was in line with the framework for radiology reporting and the granting of practicing privileges that the service had in place. The two radiologists appointed through the practicing privileges route said they had supplied all the required documentation to enable them to practice.

Contracts with radiologists for the provision of reporting services were in place. To provide reporting services through Alliance Medical Limited, radiologists provided details of their yearly appraisal, medical indemnity insurance, proof of training and employment at consultant grade on application. Enhanced disclosure and barring checks (DBS) checks were transferred across when the radiologist worked in the NHS. If the individual did not work in the NHS they had DBS checks through Alliance Medical Limited.

Bank staff received an induction prior to working on the site. Staff said bank staff had not been used for the last six months.

Records

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

The records management policy (v2.4, 7 December 2016) was due for review in two years. The policy confirmed key accountabilities and compliance with Data Protection 1998 and other key legislation. We were told and saw that patient information was encrypted. Electronic and fax transmission of confidential records adhered to Alliance Medical's information governance policies, secure fax procedure and email guidelines.

Information sharing between Alliance Medical and other organisations adhered to agreed protocols/guidance.

The imaging centre used a mixture of paper and electronic records. Staff said paper records were used for patient requests, consent and the patient safety check list. Once the patient had completed the safety check list and consent document the documents were scanned so patient's records were held electronically. Staff said the electronic records system identified who scanned the patient, whether the patient had a cannula or contrast injected and the dosage of the contrast given to the patient.

Three patient scans and associated information were reviewed from the radiology information system which we noted were fully completed.

The service was a 'scan only' service, therefore, not responsible for report distribution or reporting. However, as an additional safety check the service undertook weekly checks to ensure scans were reported by radiologists.

Medicines

Alliance Medical Limited medicines quality committee was chaired by the medical director with the support of a pharmacist. As a sub-committee of the clinical

governance committee it provided the governance and assurance regarding medicine use and supported continual quality improvement. The 'Contrast Agents and Medicines for Diagnostic Imaging Policy' was adopted by AML staff under the dual policy agreement.

Medicines and contrast solutions were provided to the service by the pharmacy within the hospital where the service was located. We reviewed some of these medicines and observed they were in date.

The Alliance Medical Limited medicines management policy (v2.4) was overdue for review. However, the provider recently informed us that a dual policy agreement existed with the local hospital healthcare provider. The service worked to the healthcare providers medicines management policy which was reviewed in October 2018.

Yorkshire Clinic Imaging Centre followed hospital patient group directions (PGD) and the medicines management policy. The PGD's and supplies of medicines were provided by the hospital where the service was located.

PGD's were used by radiographers to administer contrasts. The PGDs were not authorised in line with legislation as not all authorising signatures on PGD's were present. The hospital pharmacist had authorised the PGDs and had signed to confirm this authorisation. PGD's checked were in date when seen. The authorising signature was not signed on the record of approved practitioners' sheet on the PGD's seen. The PGD's had sections such as author and approved by, although there was not always a signature or a date against the sections. Staff had printed and signed their names against each PGD.

The radiographers who administered these contrasts had completed additional training to enable them to administer contrasts to patients safely. Staff described the training they had completed, and we saw evidence of completion of this training documented.

Contrast solutions were stored in a warming cabinet. A warming cabinet was used to warm bottles of contrast media. The outcomes from the CT contrast safety questionnaire audits showed an improvement over a two-year period. In January 2017, the contrast safety audit score was 90%; in January 2018, the audit scored 100% compliance.

Staff confirmed that contrast expiry dates were not double checked. One radiographer drew up the contrast whilst another radiographer administered the contrast.

We observed the medicines cupboard was unlocked and this area did not have restricted access. This was raised with staff and the manager at the end of the inspection.

Incidents

The service managed patient safety incidents well. Staff recognised incidents 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.

Root cause analysis training was available for managers and those staff who investigated incidents.

In 2018, 19 incidents were recorded at the Yorkshire Clinic Imaging Centre. Themes included contrast reactions, slip, trip and fall and extravasation. The risk levels identified against incidents ranged from low risk to moderate risk.

Following the inspection, we received the details of nine incidents dated from 15 August 2018 to 29 November 2019. Six were categorised as low risk and three as moderate risk. The themes identified included two contrast reactions and one near miss. We noted that appropriate actions were taken, and lessons learnt identified.

We reviewed an ionising radiation medical exposure regulation incident dated May 2018 with a staff member and saw that learning and practice changes had resulted from this incident. The 'pause and check' system was introduced in clinician's rooms to ensure the right patient was present. Duty of candour was applied and both matron and the consultant made the patient aware of the error. The provider identified an incorrect referral led to this error.

The quality and risk team reviewed reported incidents monthly to ensure all incidents, near misses and accidents were accurately reported with appropriate actions taken. Lessons learned were shared through the monthly communication bulletin, Risky Business and at staff meetings. We spoke with three staff who had received feedback from incidents reported.

Good

Diagnostic imaging

Are diagnostic imaging services effective?

Not sufficient evidence to rate

We do not currently rate effective for diagnostic imaging services.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Protocols and local rules relevant to the scanning equipment were available in the unit.

The provider had undertaken reviews of policies and procedures and these were documented in clinical governance committee meeting minutes (dated 22 May 2018). These meeting minutes confirmed 17% (48 policies) had expired and work had been undertaken to update the documents. Several policies were also approved via this forum.

We reviewed the corporate policy used for patients who were at risk of sustaining burns during a magnetic resonance imaging (MRI) session. The guidelines were in date and due for review on the 18 April 2020.

We saw how local practices were audited against local guidelines and practice. The audit schedule confirmed six-monthly auditing of MRI and computed tomography (CT) safety questionnaires. The last MRI safety questionnaire audit required no actions.

We looked at the diagnostic reference levels for the Yorkshire Clinic Imaging Centre and how scans compared to national guidelines (Gov.UK / 15 November 2018). The diagnostic reference levels were mostly within national guidelines ranges

Local audits compared the key elements of the referral and scanning pathway. This included, referral to scan time. The audit also included scan to report published time. Although, the service provided a scan only provision it audited scan to report published times to ensure the unit provided the referrer and patient with information and scan report in support of diagnosis as soon as possible. Scan image quality was reviewed by radiologists. The service had local key performance indicators (KPI's) agreed with commissioners at the point of contract agreement.

Hospital service review meetings were attended, KPI's were reviewed and outcomes discussed at unit meetings as appropriate.

Nutrition and hydration

Patients could access water, hot drinks and biscuits in the main reception areas.

Patient outcomes

Managers monitored the effectiveness of care and used the findings to improve them.

Alliance Medical Limited audit schedules for 2017 and 2018 confirmed audits in areas which related to the patient, quality, reporting, image quality, information governance, clinical systems and information technology. Audit frequency ranged from monthly to annual audits. The patient audits included compliments and complaints, patient satisfaction surveys and reported incidents.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff work performance with them to provide support.

Staff attended an induction and completed clinical skills matrix documentation when new to the service. The induction included familiarisation with policies and procedures, which included local rules specific to the scanning equipment used. We reviewed two completed induction checklists and a completed clinical skills matrix. Staff told us their clinical skills matrix was reviewed at staff yearly appraisals to determine any additional training or support needs.

Appraisal statistics confirmed all staff had received their appraisal for 2018/19. Annual appraisals were completed by the registered manager and included a mid-year review to ascertain progress made against agreed objectives. The appraisal process included a review of the staff members individual clinical skills matrix to determine training needs and/or confidence in completion of specific skills.

Good

Diagnostic imaging

Staff competencies were checked via individual cannulation audits quarterly. No themes were identified from these audits; the areas assessed included: number of cannulations, number of success attempts and unsuccessful attempts. The September 2018 cannulation audit and staff training records confirmed that all staff tested were competent to perform cannulation. Staff training records confirmed ongoing reviews of staff competency levels were completed during 2017 and 2018.

Staff attended specific courses relevant to their continuing professional development requirements. For example, one staff member had recently completed the MRI safety course in Edinburgh.

The staff we spoke with said clinical supervision was not in place, however, there were mechanisms in place for staff to discuss any significant events or to debrief as required.

Staff had designated key worker roles which included resuscitation and infection control. The key workers had not received any additional training in these areas. However, they met regularly with hospital staff and were given time back.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors and other healthcare professionals supported each other to provide good care.

Close working relationships existed with the hospital radiology department where the service was located.

Monthly multidisciplinary team meetings had taken place and included attendance by the general manager, head of finance and matron from the independent hospital.

Seven-day services

On alternate weeks the service worked seven days to allow Sunday MRI scanning to take place.

Health promotion

No health promotion information was displayed in clinical or waiting areas.

Consent and Mental Capacity Act

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.

Staff had completed Mental Capacity Act (2005) training as part of their dementia training. Training statistics confirmed 100% of staff had completed this training as of 8 January 2019.

Patients who were considered to not have capacity were referred to the person who made the original referral. Staff we spoke with understood what to do should a patient lack capacity. A hospital flowchart identified 'what actions to take if you suspect a patient may lack capacity' which was displayed in the control room.

Magnetic resonance imaging (MRI) patient safety consent forms were completed prior to the MRI scan.

Consent safety screening documentation was completed when contrasts and anti-spasmodic medication was used.

Are diagnostic imaging services caring?

Good

We rated caring as **good**.

Compassionate care

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

The provider's policy 'Privacy, Dignity and Respect' (v1) advised staff of the importance of maintaining a patient's privacy and dignity. We observed staff maintaining patients' privacy and dignity when showing the patient to a designated changing room. Staff maintained confidentiality when speaking with patients by speaking softly and closing doors.

Two patients said they were treated with compassion and quickly put at ease. We observed all staff were polite and courteous to patients from arriving to the time they left the department.

Good

Diagnostic imaging

A 'Good care, Poor Care' poster was displayed in the main reception area and requested feedback about the patient experience.

All but two responses (170) from the Yorkshire Clinic Imaging Centres patient survey from 1 May 2018 to 30 July 2018 showed patients were happy with the care and treatment they received.

Emotional support

Staff provided emotional support to patients to minimise their distress.

When patients required additional support, they were accompanied by their relative or carer.

Patients, including those patients with specific needs such as visual impairment, learning disabilities or mobility requirements, were offered the option of visiting the unit when they visited the pre-assessment clinic. Staff said this helped relieve the patients' anxieties about their forthcoming scan.

Patients were supported onto the scanner by the radiographer.

Information leaflets were available about both types of scan for patients to access.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

People's carers, advocates and family members were encouraged to be involved where the patient required support before, during and after the scan.

One patient said their questions were answered and they were given enough information pre-investigation.

One relative said they had been sent all the information and medical questionnaire prior to the appointment. They said they understood all the information provided.

We saw staff spend time with each patient prior to their scan. During this time staff went through the patient's documentation which included the patient's safety checklist. Patients and their relatives were encouraged to ask questions and confirm their understanding of the procedure they were about to have.

Staff explained what was happening by communicating with the patient throughout the scan.

Are diagnostic imaging services responsive?

Good

We rated responsive as **good**.

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people.

Computed tomography services were provided Monday to Friday. Magnetic resonance imaging scans were provided seven days a week.

The imaging service did not specifically target patient groups through its advertisements.

Yorkshire Clinic Imaging Centre had a designated patient waiting area with seating provided. One changing room and one toilet were available for patients to use. A cannulation area was in the patients waiting room.

Patients who required urgent cancer appointments were scanned within two weeks of referral.

Meeting people's individual needs

The service took account of patients' individual needs.

We did not see specific policies or guidance for staff to follow for patients who had complex needs.

Patients with complex needs such as learning disabilities or experienced mental health issues were prepared for their scan with the assistance of their named carer. This enabled the patient to be fully involved in decision making and understand why the scan was required. This also helped reduce any anxieties the patient had. Staff said patients with such needs had not attended the unit for a scan.

Patients could be accompanied into the scanner room if their needs required this support.

Information leaflets specific to MRI and CT scans were available in-patient waiting areas. Staff said there were no specific patient leaflets aimed at people with learning disabilities.

Manual handling aids for patients with differing mobilities were provided.

Posters advised patients that a chaperone service was available.

Professional translation services were obtained where patients had limited or no English language skills to support people to communicate and understand the process.

An induction loop was available for patients living with hearing difficulties. Staff said that patients with sight problems had information read to them.

The service was located on the ground floor of the hospital which made it easily accessible for a patient who used a wheel chair to mobilise.

Access and flow

People could access the service when they needed it. Waiting times from referral to scan were in line with good practice.

Ramsey Healthcare had a contract with Alliance Medical Limited to ensure patients could access CT/MRI services through the Yorkshire Clinic Imaging Centre.

Staff told us that Yorkshire Clinic Imaging Centre's remit was to provide patient scans.

The scan referral route was via post, email, GPs and consultants. On arrival referrals were date stamped and separated into routine NHS, self-funding and urgent patients. NHS patients were prioritised before the referral was made. Two patients and one relative said they had been seen quickly within a week of referral.

Once appointments and referrals were added to the Alliance database NHS referrals were reviewed. Dependant on what was required the referral was allocated to either a radiologist or radiographer.

When an NHS referral was marked 'urgent' by the referring clinician patients were scanned within two weeks of the referral.

The clinical commissioning group contract stated six weeks for NHS patients for routine MRI and CT wait times which the provider said were achieved. Waiting times at the Yorkshire Clinic Imaging Centre were audited monthly. These audits demonstrated that patients' referral to scan times were achieved which meant patients had waits of six weeks or less for their scan.

The services audited MRI wait times. Fifty percent of patients were scanned in five weeks and 25% were scanned in four weeks. This met the contractual obligations with the local clinical commissioning group.

Scans completed past the six-week deadline related to patient choice or consultant request.

Since August 2018, to reduce waiting times and increase patient choice, magnetic resonance imaging opening times had increased from 64 hours to 70 hours per week. Alternate Sunday working was implemented which increased the total scanning time over a four-week period from 256 hours to 300 hours, an increase of 44 hours.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

All staff had completed a mandatory training module on the management of complaints and customer care.

Quality and risk managers had attended an advanced course to support the management of complaints and attend regular updates.

The 'Concern's and Complaints' procedure (v5) identified the complaints process and how Alliance Medical Limited complied with 'duty of candour' by sharing information with patients, their families/carers or nominated other.

Learning was shared monthly via a monthly quality and risk bulletin 'Risky Business'. Trend analysis of complaints across the business areas helped identify similar areas of concern that were addressed at corporate and local level through the monthly quality and risk report.

The monthly quality and risk report included an overview of complaints trends discussed at board level.

Good

Diagnostic imaging

When a complaint was received by the hospital the Yorkshire Clinic Imaging Centre unit manager investigated the issues and submitted the findings to the hospital who then wrote to the complainant.

One formal complaint was received in the last 12 months. The complaint was investigated by the unit manager and reviewed by the Alliance Medical governance team and the hospital matron prior to the response letter being sent to the complainant. An action plan resulted, and a checklist was created which was used as a guide when talking with patients. The checklist was emailed to all staff and had been implemented since 15 November 2018.

We asked staff whether there had been any complaints which had triggered a 'duty of candour' response by the unit and the staff we spoke with were unaware of any complaints.

Complaints leaflets were available for patients to access.

Are diagnostic imaging services well-led?

Good

We rated well-led as **good**.

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

The Yorkshire Clinic Imaging Centre management structure (2017/18) identified clear lines of accountability to the operations manager.

Local leadership was described as approachable, although, not always visible. This was because the registered manager (RM) managed two additional locations and was generally onsite two days a week. The RM was easily contactable by phone when not on site.

We asked about visibility of the Alliance Medical Limited executive team at the unit and one staff member said they did not know who they were.

Alliance Medical Limited (AML) worked with the hospital's radiology department to provide national safety standards for invasive procedures (NatSSIPS) during interventional procedures. The nursing team provided clinical support to the AML radiologists, whilst AML radiographers scanned the patient. New employees were expected to achieve identified competencies. As staff competency levels increased their salary increased. Individual's practice was monitored by auditing image quality the outcomes of the audit were reviewed by the quarterly audit committee. This form of monitoring had been successful, and no issues were found regarding image quality. Rapid feedback from radiologists was provided if the images were poor.

There had been challenges to quality and sustainability around waiting lists and capacity and to address these challenges the scanning day was increased so that scans took place over an eight to 12-hour period and weekend scanning introduced.

Vision and strategy

The vision and values for the service had been developed for the Alliance Medical Limited group and included; Collaboration - working together and in partnership for all patients; Excellence - striving to deliver the very best to ensure the highest quality of care; Efficiency - constantly seeking new ways to use resources more intelligently; and Learning – with a commitment to ensuring learning and continuously looking for improved ways of working.

The aim of the service was to provide high standards of diagnostic imaging to meet the needs of referrers and their patients

The AML values formed the basis for staff recruitment and management and as such played a major part in the management of quality. A separately defined local strategy did not exist for the Yorkshire Clinic Imaging Centre. Staff followed the corporate strategy which was aligned with staff performance development reviews. This was how the strategy was monitored.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The service ensured that staff knowledge and understanding of duty of candour was met as it was included in the complaints handling e-learning course.

Policies and procedures were in place to support staff and provide guidance should they have concerns about a person's practice. One staff member said they would raise any concerns with the individual concerned to ascertain whether there was a training issue. They said they would also speak with the unit manager and refer to the whistleblowing policy for further advice if needed.

Staff described an open culture with good team working. The team were described as approachable, flexible and a nice team. Good relationships existed with the hospital staff and staff identified no concerns about working at the clinic.

Governance

The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

An identified governance structure was in place at the Yorkshire Clinic Imaging Centre. The medical director had overall responsibility for quality and risk within Alliance Medical Limited (AML). The AML operations structure confirmed a medical director, two directors, a consultant radiologist and a quality and risk team were in place.

The corporate 'Quality Management Framework Policy' (v5) identified sub-committees accountable to the integrated governance and risk board (IGRB). The IGRB's role provided assurance to the board that the quality and risk mechanisms in place were effective. We reviewed clinical governance meeting minutes from meetings held on the 21 November 2017 and 22 May 2018. Actions were implemented when risks or changes to practice were identified and monitoring put in place. The Alliance Medical Limited quality assurance team reviewed each imaging site annually.

The radiation protection committee, a subcommittee, of the IGRB provided assurance to the board that the governance mechanisms in place were effective.

Ongoing audit was planned through the draft audit schedule. Auditing included the patient, quality, reporting, image quality, performance and information governance. Some audits which took place in 2018 included: magnetic resonance imaging (MRI) safety screening audits, MRI and CT contrast safety screening audits.

The registered manager attended the hospital clinical governance meetings and fed back discussions to staff. Where governance feedback related specifically to incidents, for example, needle stick injuries and patients concerns staff said they had received feedback.

Staff told us that Alliance Medical Limited were good at sharing information, for example, incidents and/or complaints outcomes and what lessons were learnt because of the incident or complaint.

The hospital clinical services monthly update for November 2018 included updates which related to changes implemented following patient feedback and medicines and healthcare products regulatory agency guidance which advised the use of electronic blood pressure machines. More electronic blood pressure monitors were ordered in response to patient feedback.

Managing risks, issues and performance

The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

The medical director's responsibilities included identification of clinical or quality risks to the directors and to ensure risk was mitigated or managed.

The finance director's responsibilities included maintenance of the corporate risk register and was the identified senior information risk officer. The corporate risk register identified key risks at a national, regional and local level.

The Yorkshire Clinics Imaging Centre's local risk register was an electronic report which rated the local risks as low or moderate risks. Three moderate risks with a rating of 12 were identified. The report did not identify what actions or monitoring was in place to reduce the risks in these three areas.

Infection prevention and control activity was overseen at the infection prevention and control committee. Specialist advice was obtained from a microbiologist and reported to the clinical governance committee.

Alliance Medical Limited (AML) used a web-based incident reporting and risk management software system which were available via the AML Intranet.

Good

Diagnostic imaging

The business continuity plan (BCP) for the 'Yorkshire Clinic Imaging Centre CT/MRI' (v1.3) identified individual responsibilities and the arrangements in place to ensure that patients received their scans at identified locations should scanning equipment break down.

The radiation protection committee was a sub-committee of the integrated governance and risk board, established to provide assurance to the board that appropriate governance mechanisms were in place and effective throughout the organisation.

Monthly 'quality assurance review' (QAR) meetings took place. The meetings included discussions about audit outcomes, audit themes and recurring issues and future audit activity.

The Yorkshire Clinic Imaging Centre was monitored through the 'imaging service accreditation scheme' and ensured diagnostic imaging services patients consistently received high quality services delivered by competent staff working in safe environments. To identify potential risks annual radiation protection adviser (RPA) reviews took place and were documented in report format. The last RPA report was 10 October 2018 and no concerns were raised.

The service had indemnity insurance in place. Medical indemnity insurance expiry dates were checked monthly to ascertain whose medical indemnity insurance was due. If the medical indemnity insurance was not provided, practising privileges were revoked.

Meeting minutes from the 'integrated governance and risk board meetings' confirmed discussions in areas such as outcomes of policy audits, the bare below the elbow initiative, escalated events, radiation protection and health and safety. We noted that actions with associated timescales and responsible persons were identified for areas which required further investigation.

Managing information

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The medical director was the Caldicott Guardian.

The registered manager was the information management lead at the Yorkshire Clinic Imaging Centre.

The International Organization of Standardization standard for assuring Information Security Management Systems the ISO27001:2013 - the standard for the safe and secure management of patient identifiable data had provided external assurance to information security management. Compliance with ISO27001:2013 was maintained in 2017, and recertification achieved for a further three years, until October 2020. During this time, systems, policies and procedures were reviewed through bi-annual surveillance visits, led by an external registered auditor. Staff said no concerns were raised at the bi-annual surveillance visits of the Yorkshire Clinic Imaging Centre.

The Yorkshire Clinic Imaging Centre information technology (IT) was supported through either Alliance Medical Limited (AML) or the hospital IT department. Access to IT support through Alliance Medical Limited was available from 7:30am.

Home work stations used by the radiologists were protected by the AML fire wall set up for radiologists with AML identification protection.

Patients had the option to receive their appointment details and any other communication via email. Text messages were sent to each patient prior to their appointment as a reminder.

The registration form included terms and conditions and patients were made aware of fees.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

Monthly staff meetings took place; staff were involved in setting the agenda for staff meetings and were asked what topics they wanted to include in the meeting. These topics had included site developments, issues and changes to operational hours. Staff meeting minutes were produced and emailed to staff.

Some staff groups also met informally every two weeks to ensure that they were aware of the latest changes/ developments in the service.

Good

Diagnostic imaging

Annual staff surveys had taken place to capture staff views. The service did not provide the outcomes and action plans associated with the last staff survey.

Friends and family survey analysis 1 to 31 December 2018 showed all but one patient was very satisfied or satisfied with the service received.

Appointment booking feedback showed satisfaction with the booking process. Eighty percent of patients were satisfied with the cleanliness and appearance of the facility, 100% were satisfied and 80% were very satisfied. One hundred percent patient satisfaction related to the care provided by the Yorkshire Clinic Imaging Centre.

Patient feedback had improved the service, for example, a recurring theme from patient surveys was a lack of clarity in relation to their results. Staff now make the patient aware of what happened to their results following the scan and posters displayed in the department also informed the patient what happened to their scan results.

Private patient feedback identified limited choice in appointment times. Additional appointment times were offered as private patient slots were subsequently offered over three blocks and at weekends.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

Alliance Medical Limited had achieved the 'Investors in People Award', an internationally recognised standard for people management.

Staff attended several magnetic resonance imaging safety courses in 2018. Radiographer vetting was introduced under the scope of practice from radiologists.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that contrasts are given by the radiographer who has checked and drawn up the contrast. Regulation 12 (1) (2) (g)

The provider must ensure that medicines storage is secure. (Regulation 15 (1) (b))

The provider must ensure that all patient group directions are used in line with legislation (Regulation 12 (1) (2) (g))

Action the provider SHOULD take to improve

The provider should review their governance processes to ensure all policies are in date.

The provider should ensure that the daily checks of the warming equipment are documented.

The provider should review their records management policy (v2.4), issued on 7 December 2016

The provider should provide clear guidance in the adult safeguarding policy about female genital mutilation.

The provider should ensure that the local risk register clearly identifies the actions and monitoring in place to reduce risks.

The provider should provide clear guidance on how to support patients with complex needs.

The provider should ensure that lead aprons are checked at least on an annual basis for their shielding integrity.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure that all patient group directions are used in line with legislation The provider must ensure that contrasts are given by the radiographer who has checked and drawn up the contrast. Regulation 12 (1) (2) (g)

Regulated activity	Regulation
	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider must ensure that medicines storage is secure. Regulation 15 (1) (b))