Global Diagnostics Limited - The Global Clinic Norwich

Quality Report

Colney Hall
Watton Road
Norwich
Norfolk NR4 7TY
Tel: 01603 812266
Website: www.globaldiagnostics.co.uk

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Global Diagnostics Limited - The Global Clinic Norwich is operated by Global Diagnostics Limited. The service is located in the grounds of Colney Hall on the outskirts of Norwich. The service has four ultrasound scanning rooms, an x-ray room, three consulting rooms, a reception and waiting area. The service also provides magnetic resonance imaging (MRI) from a mobile van which remains permanently parked within the Colney Hall grounds.

The Global Clinic Norwich also provides services provided from eight satellite clinics held at five General Practitioner (GP) practices and three category B and C prisons.

The service provides diagnostic imaging to NHS and private patients aged 16 years and above.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 30 January 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.

The only service provided at this location was diagnostic imaging.

Services we rate

This was the first time we have rated this service. We rated it as **Good** overall.

- The Staff understood how to protect patients from avoidable harm, and the service worked well with other agencies to do so.
- The service had enough staff with the right qualifications, skills, training and experience to provide the right care and treatment.
- Information leaflets were provided in the service for patients on what the scan would entail and what was expected of them prior to their scan.
- Staff cared for patients with compassion. 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.
- The service planned and provided services to meet the needs of local people whilst taking into account the patient's individual needs.
- Patients could access the service in a timely manner.
- The service treated concerns and complaints seriously and sought patient feedback through a variety of methods.
- Written feedback from patients was consistently positive.
- The service had a clear mission statement in place with workable plans to turn it into action.
- Managers across the service promoted a positive culture that supported and valued staff.

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

Summary of findings

- Equipment such as a wheelchair and trolley in MRI unit were not labelled as 'magnetic resonance (MR) conditional' or 'MR safe', to indicate that these pieces of equipment were safe to use in an MR environment as per the Medicines & Healthcare products Regulatory Agency (MHRA) safety guidelines for magnetic resonance imaging equipment.

Amanda Stanford

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good	Global Diagnostics Limited - The Global Clinic Norwich is operated by Global Diagnostics Limited. The service provides diagnostic imaging services the local communities Norfolk and Waveney. The services are commissioned by five clinical commissioning groups (CCGs), the local NHS acute trust and community trust. The service is registered to provide diagnostic imaging services to patients aged 16 years and above. We rated this core service as good overall because care and treatment provided was based on best practice and delivered by competent staff. The service controlled infection risk well and had an updated infection prevention and control policy. Patients could access care and treatment in a timely way and in locations to meet their needs. Patient feedback about the service was positive. Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Governance processes were in place to provide adequate assurances of service provision and drove forward service improvements

Summary of findings

Contents

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Services we looked at
Diagnostic imaging

Summary of this inspection

Background to Global Diagnostics Limited - The Global Clinic Norwich

Global Diagnostics Limited - The Global Clinic Norwich is operated by Global Diagnostics Limited. The service opened in 2006 and is based in Norwich. The service primarily serves the communities of Norfolk and Waveney. The service is registered to provide diagnostic and screening procedures to patients aged 16 years and above.

The service has had a registered manager in post since 2012. At the time of the inspection, a new manager had been appointed and was registered with the CQC in June 2018.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise in radiology. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Information about Global Diagnostics Limited - The Global Clinic Norwich

The service is provided from the grounds of Colney Hall on the outskirts of Norwich and is registered to provide the following regulated activities:

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

During the inspection, we visited the location in Norwich. We spoke with nine staff including radiographers, a registered nurse, administrative staff and senior managers. We spoke with two patients and two relatives. During our inspection, we reviewed ten sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since its registration with CQC.

Activity (January 2018 to December 2018)

- In the reporting period January 2018 to December 2018 the service saw 22,596 patients; 9,507 for Magnetic Resonance Imaging (MRI), 12,431 ultrasound scans (US) and 658 for x- rays; of these 96% were NHS-funded and 4% privately funded.

The service employed 23.4 full time equivalent (FTE) members of staff which consisted of: 4 FTE MRI radiographers, 0.9 WTE x-ray radiographers, 2 FTE register nurses, 3.4 FTE clinical assistants, 2 FTE managers and 11.7 FTE administration & clerical staff. The service accessed sonographers employed by NHS trusts to provide regular sessional work to meet service demands.

Track record on safety

- There were no never events
- There were no serious events
- There were no Ionising Radiation Medical Exposure Regulations reportable incidents (IRMER)
- There were no Ionising Radiation Regulations reportable incidents (IRR)
- There were no clinical incidents.

Summary of this inspection

No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),

No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)

No incidences of hospital acquired Clostridium difficile (c.diff)

No incidences of hospital acquired E-Coli

Ten complaints.

Accreditation by a national body:

- International Organization for Standardization (ISO 9001:2015 standards), ISO 9001 is an international standard that specifies requirements for a quality management system, used by organisations to demonstrate the ability to consistently provide products and services that meet customer and regulatory requirements.

Services provided under service level agreement:

- Clinical and or non-clinical waste removal
- Maintenance of medical equipment
- Provision of radiation protection advice
- Medical physics quality assurance and expert service

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

This was the first time we have rated this service. We rated it as Good because:

- Staff received mandatory training in safety systems, processes and practices.
- Staff kept patients safe from harm and abuse. Patient were risk assessed, monitored and managed appropriately.
- Staff followed best practice in relation to infection prevention and control.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- Staff recognised incidents and knew how to report them. Managers investigated incidents and made improvements to the service.

However:

Equipment such as a wheelchair and trolley used for transferring patients from the magnetic resonance imaging (MRI) scanner in an emergency were not labelled as 'MR conditional' or 'MR safe', to indicate that these equipment were safe to use as per the MHRA safety guidelines for magnetic resonance imaging equipment.

Are services effective?

We do not currently rate diagnostic imaging services for effective, however, we found:

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- The service checked to make sure staff followed guidance through the process of local audit.
- Managers monitored the effectiveness of care and treatment and used the findings to improve the service.
- Staff understood how and when to assess whether a patient had the mental capacity to make decisions about their care.

Are services caring?

Good

This was the first time we have rated this service. We rated it as **Good** because:

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

Summary of this inspection

- 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

This was the first time we have rated this service. We rated it as **Good** because:

- The service planned and provided services in a way that met the needs of local people.
- The service took account of patients' individual needs.
- Patients could access the service when they needed it.
- The service treated concerns and complaints seriously, investigated them, learned lessons from the results and shared these with all staff.
- The service was open seven days a week and provided appointments that were convenient for patients.

Are services well-led?

Good

This was the first time we have rated this service. We rated it as **Good** because:

- Service leaders had the capacity and capability to deliver high-quality, sustainable care.
- The service had a clear vision and strategy that all staff understood and put into practice.
- Staff described the culture within the service as open and transparent. Staff could raise concerns and felt listened to. They said leaders were visible and approachable.
- The service had governance, risk management and quality measures to improve patient care, safety and outcomes.
- The service had effective systems in place to capture patient feedback.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Good

This was the first time we have rated this service. We rated it as **good.**

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Mandatory and statutory training was provided by a combination of e-learning and face-to-face training sessions, including adult and paediatric basic life support, infection prevention and control, fire safety, moving and handling, health and safety, risk assessments, equality and diversity, safeguarding children level 2, vulnerable adults level 2, information governance and conflict resolution.
- The service had a training matrix with a 'traffic light' system which would alert the manager when training was due to be completed.
- The mandatory training year started in July. Compliance rates were reviewed annually. The service had set mandatory training compliance rate of 80% by 31 March 2019 and 95% completion by 30 June 2019.
- At the time of our inspection, 73% of staff had completed their mandatory training. The remaining were in the process of undertaking their mandatory training or recently started working for the service.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.**
- The service had a safeguarding children and vulnerable adult's policy including guidance on female genital mutilation (FGM). The safeguarding policy contained definitions of abuse, signs of potential abuse and the definition of FGM. The policy contained up to date contact details for the local authority and clear guidance on the process staff should follow if they suspect abuse or harm. We reviewed the safeguarding policy which referenced national guidance it was dated April 2018 and had a review date April 2019. Staff had access to the safeguarding policy on the electronic shared drive.
- All the staff we spoke with demonstrated they understood safeguarding processes and how to raise an alert. They could access support from senior staff if needed. Staff were aware of their responsibilities to protect vulnerable adults and children.
- The service had a named safeguarding lead who was trained to level three safeguarding adults and children.
- Safeguarding children and vulnerable adults formed part of the mandatory training programme. Staff we spoke with told us they had received safeguarding training. Records provided by the service showed that 80% of staff had completed adult 's safeguarding level two training.
- The service treated 15 young people age 17 years in the 12 months prior to the inspection. Records provided by the service showed that 82% of staff had completed children's safeguarding level two training.

Good

Diagnostic imaging

- There had been no reported safeguarding incidents in the reporting period October 2017 to September 2018.
- The service had an up to date chaperone policy. Staff were available for any patient requiring or requesting chaperoning.

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.**
- The service had an updated infection prevention and control policy, which set out staff responsibilities in relation to infection prevention, including hand hygiene.
- Infection control training formed part of the mandatory training programme for staff. Data provided by the centre showed that only 54% clinical staff had completed infection control training. At the time of inspection staff were either in the process of undertaking their annual infection prevention and control training or recently started working for the service.
- The service undertook an annual infection control audit to check compliance with the infection control and prevention policy. The most recent annual audit reported in October 2018 demonstrated 100% compliance.
- The service had a dedicated infection control lead. All areas were visibly clean and well maintained. Daily checklists for cleaning were seen from November 2018 to January 2019 and all were completed fully.
- Examination couches, chairs and pillows had wipeable covers and we saw disinfectant cleaning wipes throughout the service.
- Personal protective equipment (PPE) such as disposable gloves and aprons were readily available for staff to use.
- Hand washing posters were in appropriate areas, demonstrating best practice hand washing techniques.
- During our inspection, we observed staff were bare below the elbows even when not working clinically. Bare below the elbow national guidelines are for all staff working in healthcare environments to follow to reduce the risk of cross contamination between patients.
- Hand hygiene audit results for March 2018 and October 2018 were 100% and 93% respectively, against the providers' target of 98%. This had been shared at the team meeting and actions put into place to improve staff compliance.
- Waste was handled and disposed of in a way that kept people safe. Staff used the correct system to handle and sort different types of waste and these were labelled appropriately.
- Sharps management complied with Health and Safety and the Sharp Instruments in Healthcare Regulations 2013. We saw sharps containers were used appropriately and they were dated and signed when brought into use.
- The service had a suitable Control of Substances Hazardous to Health (COSHH) policy and procedures for staff to follow. Most COSHH risk assessments were in place and up to date. However, there was no COSHH risk assessment for the Chromium (CR) Phosphate cleaner and there was no personal protective equipment (PPE) stored with this chemical in order to handle and use safely as per manufacturer guidelines. We escalated this with the lead x-ray radiographer. The COSHH risk assessment for this chemical and the correct PPE were put in place immediately.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
- The service's reception area had a reception desk that was staffed during opening hours. The reception area provided a range of magazines, refreshments and toilet facilities for patients and relatives to use.
- The MRI facilities were located in a mobile van which remained permanently at The Global Clinic site. At the time of our inspection, the service was in the process of commencing works to build a permanent magnet MRI which was due to be completed by the end of 2019.

Good

Diagnostic imaging

- The fringe fields around the MRI scanner were clearly displayed and staff we spoke with were aware of the fringe field. The fringe field is the outer magnetic field outside of the magnet core. Depending on the design of the magnet and the room, a quite large fringe field may extend for several metres around the MRI scanner.
- There was sufficient space for staff to move around the scanner and for scans to be carried out safely. During scanning, all patients had access to an emergency call / panic alarm, ear plugs and ear defenders. Patients could have music played whilst being scanned. There was a microphone which allowed contact between the radiographer and the patient at all times.
- In accordance with Medicines and Healthcare Products Regulatory Agency (MHRA) guidance, the MRI van was equipped with oxygen monitors to ensure that any helium gas leaking, for example liquid nitrogen or liquid helium would be identified. This ensured that oxygen levels remained safe not compromising patient safety.
- The service had a MRI safe wheelchair and trolley available for transferring patients from the scanner in an emergency situation. However, this equipment was not labelled as 'MR conditional' or 'MR safe', to indicate that these pieces of equipment were safe to use in an MR environment as per the MHRA safety guidelines for magnetic resonance imaging equipment. We escalated the issue to the MRI radiographer lead and the senior management team, who said they would get the items labelled accordingly.
- On the day of the inspection, we observed that the ramp to the MRI van was down at ground level while a patient was being scanned. This was not in keeping with the MRI safety policy and could potentially delay the process of removing a collapsed or unwell patient from the MRI scanner. We escalated the issue to the MRI lead and the senior management team, who rectified the issue immediately.
- The x- ray room was accessed off the main reception. The room where radiation exposure took place was clearly marked with warning signs and lights. Unauthorised access was restricted. We saw warning signs and lights in use on the day of our inspection, all areas were monitored and had oversight from the reception staff.
- Lead screens were in place to protect staff from radiation. These were checked on a annually basis by the service's medical physics expert.
- Lead aprons were available for use if required and were subject to regular integrity checks by the service's medical physics expert.
- Staff working within areas exposed to radiation wore dosimeters. A dosimeter is a device that measures exposure to ionising radiation.
- There were systems to ensure repairs to machines or equipment when required, which were timely. This ensured patients would not experience prolonged delays to their care and treatment due to equipment being broken and out of use. Servicing and maintenance of premises and equipment was carried out through a planned preventative maintenance programme.
- There were processes in place to ensure equipment was serviced in accordance with the manufacturer's guidance. All the equipment we checked, was within the service date.
- The service had two sets of resuscitation equipment. One was located in the main reception area near the x-ray and ultrasound rooms and the other was located in the MRI waiting area.
- Both sets of emergency equipment were visibly clean and had been serviced. Both resuscitation equipments were tagged to indicate whether equipment had been tampered with.
- Staff carried out resuscitation equipment and consumable checks twice a month. We reviewed the records for resuscitation equipment checks from November 2018 to January 2019, and these were completed accordingly.
- Clinical waste bins were clearly identified and located throughout the departments. Different coloured lining bags were in use to ensure correct segregation of

hazardous and non-hazardous waste. The service had a service level agreement with a third party for the management and removal of clinical and non-clinical waste.

- There were a range of fire extinguishers, which were strategically placed. All fire extinguishers that we reviewed were up-to-date with servicing.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient.**
- The service used a magnetic resonance imaging (MRI) patient safety questionnaire. Risks were managed and updated in line with any change in the patient's condition.
- Processes were in place to ensure the correct patient received the correct radiological scan at the right time. The service did have a Society of Radiographers (SoR) 'pause and check' poster within the unit. The posters were used as a reminder for staff to carry out checks on patients.
- We saw staff checking three-points of demographic checks to correctly identify the patient. Completing the 'pause and check' provides assurance that the MRI operator used the correct imaging modality, the correct patient and correct part of the body was scanned. Using the 'pause and check' also decreases the number of wrong site scans.
- In the event of an emergency, there were procedures in place for removal of a collapsed patient from the MRI scanner. We saw records of a practice evacuation of a patient from the MRI. Staff had used the MRI safe wheelchair. Staff were confident in their explanation of what they would do in the event of having to remove a patient from the scanner in an emergency situation.
- The service had a radiation protection advisor (RPA) and medical physics expert (MPE) supplied through a service level agreement (SLA). We reviewed the SLA and noted it was in date.
- All staff described the RPA and MPE as responsive and contactable at all times.
- The service had a nominated radiation protection supervisor (RPS) in post. The RPS ensured compliance with the Ionising Radiations Regulations 2017 in respect of work carried out in an area which is subject to Local Rules.
- Clear signage was in place to warn patients of areas where radiation exposure took place, therefore, preventing unrestricted access.
- Each clinical area contained an emergency alarm cord in the event of emergency or patient collapse.
- Local rules were in place to ensure the health and safety of patients and staff in areas where ionising radiation was in use. Details of the RPS and RPA were included in the local rules, which was in line with the Ionising Radiations Regulations 2017 (IRR 17).
- Staff had access to a medical physics expert in the event of advice being required regarding diagnostic reference levels (DRLs). DRLs are a tool to optimise levels of radiation.
- Pregnancy status was routinely checked prior to any imaging taking place. Staff confirmed the patients name, date of birth and address, confirmation of pregnancy status, and also ensured the patient had read information on procedure to be carried out. We saw these checks being carried out on the day of our inspection.
- There were clear pathways and processes for staff with regards to people using the service who became unexpectedly unwell or if an unexpected result was found during the scan. If a patient required urgent treatment staff told us they would call 999 for an emergency transfer to the local hospital.
- All reception staff were basic life support (BLS) trained, 41% of clinical staff were also BLS trained. Should a patient require emergency first aid treatment, staff would ring 999 and then commence basic life support until the emergency services arrived. A BLS and first aid trained member of staff was available at all times during service opening hours.
- Senior management team told us and we saw evidence that staff have been booked to complete BLS training by the 30 June 2019.

Radiographers and Nurse staffing

Good

Diagnostic imaging

- **The service had enough staff with the right qualifications and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- Staffing levels were planned and reviewed in advance to ensure that an adequate number of suitably trained staff were available for each clinic.
- The service employed four whole time equivalent (WTE) MRI radiographers, 0.9 WTE x-ray radiographers, two WTE registered nurses, 3.4 WTE clinical assistants.
- The service utilised a pool of eight WTE bank sonographers to provide the ultrasound scanning service. They were offered the same training as regular staff and competencies were monitored.
- The service used agency when required. In the three months prior to 1 October 2018, a total of 75 shifts had been carried out by agency staff. This included 25 shifts for MRI radiographers and 36 shifts for clinical assistants.
- The service had vacancy for one WTE MRI radiographer, a 0.4 WTE clinical assistant and one WTE patient booking administrator. These posts had been out to advert and at the time of our inspection the clinic manager told us that the radiographer and clinical assistant posts had been recruited into.
- The service had set minimum staffing requirements for all sessions. This included one receptionist, a radiographer and a clinical assistant. Which meant there were suitably skilled and qualified staff available at all times.

Medical staffing

- The service had access to a radiologist to provide additional medical advice when needed.
- Bank radiologists were also utilised by the service. Data provided by the service showed in the three months prior to 1 October 2018, a total of 156 shifts were covered by bank radiologists. These were a central bank of radiologists that were utilised for second opinions and to report on scans.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**
- Staff completed a MRI safety consent checklist form with patients over the phone. The patients' consent and answers to the safety screening questions were recorded electronically and kept as part of the patients' electronic records.
- Patients' records and information was kept secure and only authorised staff had access to the information. Staff received training on information governance as part of their mandatory training.
- Prior to completing a scan, staff confirmed that the patient had consented and updated the electronic records. Once the scan was completed, staff submitted the images to a radiologist for reporting.
- We reviewed 10 patient records during our inspection and saw records were accurate, complete, legible and up to date.
- The service provided electronic access to diagnostic results and could share information electronically if referring a patient to a hospital.
- The service used radiology information system (RIS), picture archiving and a communication system (PACS) to load the images for the scans and for sonographers or radiologists to report and transfer to the referring clinician. Both these systems were secure and password protected. Each member of staff had their own password to access the information system.
- The service had an up-to-date policy for records management and information lifecycle. The policy provided staff clear guidance on the storage, retention period and destruction of records according to current information and data protection guidance.

Medicines

- The service did not stock or administrator medicines as they were not required in this setting or for the type of services offered.

Incidents

Good

Diagnostic imaging

- **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.**
- An up-to-date incident reporting policy and procedure was in place to guide staff in the process of reporting incidents.
- Staff reported incidents using an electronic form.
- There were no never events reported for the service from October 2017 to September 2018.Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- From October 2017 to September 2018, there were no serious incidents reported for the service. Serious incidents are events in health care where there is potential for learning or the consequences are so significant that they warrant using additional resources to mount a comprehensive response.
- The service reported 107 incidents from October 2017 to September 2018. These incidents were subcategorised as; 54 clinical, 16 information governance, seven equipment, 10 health and safety, 19 medical records and one safeguarding.
- We reviewed four of the most recent incidents reported. These were all investigated appropriately and any immediate actions and lessons learnt shared with staff.
- Learning from incidents was shared with staff at regular staff meetings, by email and through the service's monthly bulletin.
- Incidents were reviewed weekly at the Quality, Safety and Compliance (QSC) committee meeting. The QSC team analysed incidents and identified themes and shared learning to prevent reoccurrence at a local and organisational level.
- Staff used a specific form to record and report radiation doses greater than the intended dose. The service had a named radiation protection advisor (RPA) who would review any incidents relating to radiation. There had been no radiation incidents in the 12 months prior to our inspection.
- The service reported no incidents from October 2017 to September 2018 that met the requirements of duty of candour from. Duty of candour is a regulatory duty under the Health and Social Care Act (Regulated Activities Regulations) 2014 that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- During the inspection, we spoke with three members of staff regarding duty of candour. All three staff members could tell us their understanding of the requirements of the duty of candour regulation. The clinic manager and the governance lead could explain the process they would undertake if they needed to implement the duty of candour following an incident which met the requirements.

Are diagnostic imaging services effective?

We do not currently rate effective for diagnostic imaging.

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.**
- We reviewed policies, procedures and guidelines information, which referenced guidance from professional organisations such as the National Institute for Health and Care Excellence (NICE), Medicines, the Healthcare Products Regulatory Agency (MHRA) and the Department of Health (DoH).
- Staff easily accessed policies, procedures and guidelines via the service's electronic system.
  The provider had an audit plan in place. Local audits were completed monthly, quarterly and annually to

assess clinical practice in accordance with local and national guidance. Topics audited included infection and prevention control, patient feedback, waiting times, report turnaround times and equipment audits.

- The service used the Society of Radiographers (SoR) 'pause and check' poster within the unit. The posters were used as a reminder for staff to carry out checks on patients. Completing the 'pause and check' provides assurance that the MRI operator used the correct imaging modality, the correct patient and correct part of the body was scanned. Using the 'pause and check' also decreases the number of wrong site scans.

Nutrition and hydration

- Due to the nature of service provided, food was not routinely offered to patients. Patients had access to water and hot drinks whilst awaiting for their scan. During our inspection, we observed staff offering patients drinks before and after they were scanned.

Pain relief

- Staff assessed and monitored patients regularly to see if they were in any pain during the procedures. We saw staff frequently asking patients if they were comfortable during their procedure.

Patient outcomes

- **Managers monitored the effectiveness of care and treatment and used the findings to improve them.**
- The service reported on the time taken between a referral being received for a scan and the time it took for a scan to be booked. They also recorded the time from the scan to when the scan was reported on. The information was collated and reported on monthly. This formed an integral part of the key performance indicators (KPIs) the service had to present to the commissioners of the service. We reviewed the data from April 2018 to December 2018 and the service was 100% compliant.
- The service commissioned an external auditor to audit the report quality, the image quality and the risk to the patient. The results of these audits and any issues that were identified were fed back to the consultant radiologist of the organisation and the service used it for quality assurance purposes and learning and improvement.
- An annual local audit plan was in place and used to drive service improvements. Areas audited included, privacy dignity and respect, infection control and prevention, hand hygiene, uniform, and equipment.
- The results from the audits were discussed at clinical governance meetings and shared with the wider team for learning and action.
- Patient feedback was captured through electronic tablet or in paper format. Details on how to give feedback was displayed on notice boards, television screens throughout the clinic and was also publicised on the website.
- The clinic manager and the governance lead told us that patient feedback was reviewed monthly. Any dissatisfied patients, if they left their contact details, would be contacted by the governance lead to try and resolve the issues raised. We noted the majority of feedback was positive about the staff and the speed of access to having a scan.

Competent staff

- **The service made sure staff were competent for their roles.**
- All staff received a local and corporate induction and completed an initial competency assessment. Staff we spoke with told us the local induction provided assurance that staff were competent to perform their required role. For clinical staff, this was supported by a comprehensive competency assessment toolkit. This covered key areas applicable across different staff roles including equipment and clinical competency skills relevant to their role and experience.
- Staff skills were assessed as part of the recruitment process, at induction, through the probation period and then ongoing as part of the continuous professional development (CPD) process.
- Performance of radiographers and sonographers was monitored through peer review and external quality audit. Any issues were discussed in a supportive

environment. Radiologists fed back any performance issues with scanning to enhance learning or highlight areas of improvement in individual radiographers' performance.

- All radiographers employed by the service were registered with the Health and Care Professions Council (HCPC) and met HCPC regulatory standards to ensure the delivery of safe and effective services to patients.
- Data provided by the service showed that 82% of staff had completed an appraisal in the last 12 months prior to the inspection. The clinic manager told us that organisation was reviewing the appraisal process to make it meaningful and to help set professional development goals. We saw evidence of planned appraisal dates for the senior management team and team leads to roll out the new appraisal process.

Multidisciplinary working

- **Staff of different kinds worked together as a team to benefit patients.**
- Staff told us that they worked closely with other providers who referred patients to their service to provide a seamless treatment pathway for patients.
- Staff told us there was good communication between services and there were opportunities for them to contact other providers for advice, support and clarification.
- We saw evidence of effective multi-disciplinary working with communications between the service, GPs and local commissioning group.
- The service had systems and processes in place to communicate and refer to the local hospitals or the referring clinician in the event of further examination and or treatment being required. We saw evidence that reports to other healthcare professional took place in a timely manner.

Seven-day services

- The service opened seven days a week with varying opening hours. The MRI service operated a 15 hour a day service from Monday to Friday 6.30am to 10pm. A 13 hour service was available from Saturday and Sunday 7am to 8pm.
- The ultrasound service operated a 12 hour service from Monday to Friday 8am to 8pm. When there was an increased demand for appointments the service provided additional ultrasound clinics every other Saturday from 8am to 2pm. This enabled the service to offer a range of appointment times to suit patient needs.

Health promotion

- Information leaflets were provided for patients on what the scan would entail and what was expected of them prior to a scan. The service also provided information to patients on self-care following a scan.

Consent and Mental Capacity Act

- **Staff understood how and when to assess whether a patient had the mental capacity to make decisions about their care.**
- Staff had access to a consent policy. The policy referenced the Mental Capacity Act (MCA) 2005 and provided guidance for staff regarding processes for assessing capacity and obtaining consent. The policy had been regularly reviewed and was due for further review in April 2019.
- We reviewed 10 medical records which demonstrated that written documented consent was obtained prior to the patient's procedure.
- All staff we spoke with were clear in their responsibilities with obtaining and documenting consent.
- Staff were aware of children's consent procedures. The service only saw young people aged 17 and above. Young people (aged 16 or 17) were presumed to have sufficient capacity to decide on their own medical treatment, and provide consent to treatment, unless there was significant evidence to suggest otherwise.

Are diagnostic imaging services caring?

Good

This was the first time we have rated this service. We rated it as **good.**

Compassionate care

Good

Diagnostic imaging

- **Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.**
- We observed staff treating patients with dignity, courtesy and respect. We observed that staff introduced themselves prior to the start of a patient's imaging scan, interacted well with patients and included patients during general conversation.
- Patients we spoke with described staff as caring and kind.
- Patient feedback was consistently positive. We reviewed the feedback report for November 2018 and December 2018. All comments were positive and included; 'lovely friendly staff', 'friendly, helpful and caring', 'friendly and polite', 'lovely staff, quick and efficient, kind and reassuring' and 'expert professional and caring'.
- Staff ensured patients' privacy and dignity was maintained at all times. The service provided changing rooms for patients and ensured patients were covered as much as possible during procedures to preserve their modesty and dignity.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- Staff had a good awareness of patients with complex needs and gave examples of how they would deal with anxious or challenging behaviour.
- Staff talked to patients who were anxious and discussed the processes thoroughly. The service completed a questionnaire over the phone with patients at the time of booking to check if patients were claustrophobic. This would be flagged on the electronic patient record.
- Staff stopped scanning immediately if requested by the patient. They discussed with the patient how they wished to proceed and would arrange for the patient to come back another day to complete the scan if the patient felt unable to continue.
- We observed staff providing ongoing reassurance throughout the scanning procedure, they updated the patient on how long they had been in the scanner and how long was left.
- The service allowed family members or carers to accompany patients who required support into the scanning area.
- We reviewed patient feedback from November 2018 and December 2018, and comments included, 'put me at ease and explained everything they were gonna do', 'I felt very welcome which made me more at ease', 'kind and reassuring', 'staff were fantastic, you can't help to worry about but they made you feel at ease'.

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.**
- Staff recognised when patients and those close to them needed additional support to help them understand and be involved in their care and treatment and enabled them to access this. This included for example, access to interpreting and translation services
- We observed that staff answered patients' questions appropriately, and in a way they could understand. Staff explained to patients how and when the results would be sent to their GP or the referring clinician.
- The service provided a wide range of information on its website relating to MRI scans, ultrasound scans and x-rays and what patients could expect during their appointment.

Are diagnostic imaging services responsive?

Good

This was the first time we have rated this service. We rated it as **good.**

Service delivery to meet the needs of local people

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

Good

Diagnostic imaging

- The service was planned and designed to meet the needs of the patients. Information about the needs of the local population and the planning and delivery of services was agreed collaboratively with the individual Clinical Commissioning Groups (CCGs) and the service.
- The service provided evening and weekend appointments to accommodate the needs of patients who were unable to attend during the day time on week days.
- To meet contractual requirements the service was expected to meet key performance indicators (KPIs) around waiting times for routine scans. Data from April 2018 to December 2018 showed 100% patients were seen for routine MRI ultrasound scans within 30 days of the initial referral.
- The service was expected to meet KPIs around report times. For the reporting period of April 2018 to December 2018, 100% of MRI and ultrasound scan reports were sent to the referring clinician within two working days following examination, against a target of 80%. This meant any onward treatment or further examinations could be organised effectively and without delay.
- Patients were greeted when they entered the service and accessed a comfortable waiting area, there were toilet facilities available for people to use.
- There was adequate seating areas within the service, it was well lit and patients and visitors had access to free refreshments. Waiting areas were designed to provide a calm environment to make the patient visit as relaxing as possible.
- A lift was available to facilitate ease of access to patients with additional mobility needs. The service and all areas within the service were accessible to wheelchairs users.
- The service was accessible to all patients. The service was within a mile of public transport. There was ample free car parking facilities for patients to use, with designated disabled parking.
- The service's website gave people useful information about the service it provided, its other clinic sites and the referral processes.

Meeting people's individual needs

- **The service took account of patients' individual needs.**
- During the scan, we saw staff making patients as comfortable as possible. For example, for patients having MRI scans they used padding aids, ear plugs and ear defenders to reduce the noise of the procedure. They ensured the patient was in control throughout the scan and gave them an emergency call buzzer to allow them to communicate with staff if they needed to. The MRI scanner had built in microphones to enable a two-way conversation.
- We saw patients being advised should they wish to stop their examination, staff then assisted them and discussed choices for further imaging or different techniques and coping mechanisms to complete the procedures.
- An interpreting service was available for patients whose first language was not English. The interpreting service was available through a telephone line service and was arranged for patients requiring it.
- Staff completed dementia awareness training and wore 'Forget me not badges' to identify themselves as support to patients, visitors or carers living with dementia. The service introduced this initiative as a response to needs of a patient's spouse who was living with dementia. At the time of booking, the patient mentioned that their spouse needed additional support whilst they had their scan. The service coordinated and made sure that a staff member kept the spouse company while the patient proceeded with their scan without the worry of their spouse being left by themselves.
- The service had a clear exclusion criterion which included a comprehensive list of who they were unable to provide services to. This included but was not limited to, patients requiring general anaesthetic, patients who were medically unfit to undergo the diagnostic scans requiring the use of contrast media, scans for superficial masses or lumps in the neck, axilla or groin areas.

Access and flow

Good

Diagnostic imaging

- **People could access the service when they needed it. Waiting times from referral to treatment and arrangements to treat patients were in line with good practice.**
- Access to the service was monitored through key performance indicators (KPIs) monitoring in conjunction with the local clinical commission group (CCG).
- People could access the service when they needed it. Patients were offered a choice of appointment and to a nearer location to their home address if required.
- Referrals were received from GPs by e-referral, email, choose and book and through a secure NHS email address.
- All referrals were triaged by the radiographers who reviewed and confirmed suitability of patients. For complex cases the staff could seek assistance from the Global Diagnostics consultant radiologist.
- The service booked appointments up to three weeks in advance. Waiting times were monitored by the registered manager with additional clinics added where demand required.
- Patients awaiting ultrasound or MRI examinations were classed as either routine or urgent, specified by the referring clinician. The service aimed to offer routine appointments within 30 days and urgent appointments within ten days.
- Figures from April 2018 to December 2018 showed that 100% of patients were contacted within a maximum of five working days of acceptance of referral.
- To meet contractual requirements, the service was expected to meet KPIs around waiting times for routine scans. Data provided from April to December 2018 showed the percentage of patients for MRI scan seen within 30 days of the initial referral met the 100% threshold. For the same reporting period, between 97% and 100% of patients for ultrasound scans were seen within 30 days of the referral being accepted.
- The service ensured that diagnostic reports were produced and shared in a timely fashion and closely monitored KPIs. Data from April 2018 to December 2018 showed that 100% of routine MRI and ultrasound reports were sent to the referrer within two working days following examination, against a KPI target of 80%.
- For the same period the 100% of urgent and/or suspected cancer MRI and ultrasound reports were discussed with the referring clinician within two working days.
- From April 2018 to December 2018, the service cancelled 145 planned procedures for non-clinical reasons. These were mainly due to machine breakdown or other equipment failure and lack of staff availability due to adverse weather conditions. The booking administrator told us that patients were given alternative appointments and where possible, additional clinics were booked to accommodate the patients who had been cancelled.
- Rates of those who did not attend (DNA) were documented and monitored by the clinic manager. Staff contacted all patients that DNA to ensure a new appointment was booked in a timely manner. From April 2018 to December 2018, 1.5% of patients did not attend.

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.**
- The service had an up to date concerns and complaints management policy.
- The service reported they had received 10 complaints during the period September 2017 to October 2018. The complaints were investigated and responded to in line with the policy. Where applicable a response was sent to the complainant within 21 working days from the date of receiving the compliant.
- Staff explained how complaints were managed, the responses included an apology to the patient, any lessons learnt from the complaint shared and actions implemented. In addition, the service utilised a "you said we did" on the television screens within the waiting areas which showed the outcomes and changes from the patient complaints and feedback form.

- Learning from complaints was communicated to staff through staff meetings and through the staff bulletins.

Are diagnostic imaging services well-led?

Good

This was the first time we have rated this service. We rated it 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 clinic manager, who was also the registered CQC manager, had overall leadership of the service supported by the Global Diagnostics senior management team (SMT). The SMT consisted of the radiology service manager, governance manager, clinical assurance lead, information management and governance (IM&G) manager, finance and human resources manager.
- Locally the day to day running was led by the operational lead and the designated clinic leads for each modality.
- Staff we spoke with told us that the leaders were visible, accessible, approachable and supportive.

Vision and strategy

- **The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff and patients.**
- The Global Diagnostics had a strategic plan and vision in place. These were to:
  - Exceed patient expectations
  - Enable excellence through people
  - Strengthen local clinical services
  - Focus on quality and safety
  - Ensure a sustainable future
- The service had clear core values which were, "patient centred, relationships based on trust, power of the team, pride in what is does, humility in how it is done and courage to fulfil potential".
- All staff were introduced to the Global Diagnostics strategic plan and vision through the 'plan on a page' document which was incorporated within the quality policy. New employees received a copy of the company handbook and the 'plan on a page' during the corporate induction process.
- The SMT told us that the organisation's strategic plan was aligned to the Sustainable Transformation Plans (STP) of each region that they delivered services to.

Culture

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- Staff were consistently positive when describing the culture within the service. They felt supported by all leaders and colleagues within the service.
- During our inspection we saw that staff interacted and engaged with each other in a polite, positive and supportive manner.
- Staff reported feeling supported by the clinic manager, describing them as 'nice, accessible and supportive'.

Governance

- **The service systematically improved service quality and safeguarded high standards of care by creating an environment for clinical care to flourish.**
- We viewed a number of policies that the service had in place including; consent policy, incident reporting policy, concerns and complaints management policy, privacy dignity and respect policy, adult and children's safeguarding policy, records management and lifecycle policy and resuscitation policy. All the policies had implementation and review dates, they contained references from national bodies such as the National Institute for Health and Care Excellence (NICE).
- The governance council meetings were held every other month. However, some meetings were cancelled

due to operational pressures. We reviewed the minutes of the meetings from December 2017, March 2018, April 2018 and September 2018. We observed topics that were discussed included clinical effectiveness by clinical area and audit results.

- Global Diagnostics operated a clinical governance and assurance framework which aimed to assure the quality of services provided. Quality monitoring was the responsibility of the Global Diagnostics country manager and was supported through the senior management team and the governance committee structure of the service. This included governance council, information management and governance board and clinical advisory group.
- The senior management team had a monthly meeting. We reviewed the minutes from the meetings in September 2018, October 2018, December 2018 and January 2019. Operational issues, human resources update, governance, finance and information management and governance were standing agenda items. The SMT kept an actions log, which ensured that actions were followed up to completion.
- In addition the service had clinical effectiveness meetings and a radiation protection group. All these meetings had a standard agenda and were minuted with an actions log. This ensured the actions to improve services were recorded and monitored to completion.

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 service held a risk register with identified risks. The registered manager had oversight of the management of the identified risks through the clinical governance meetings. Some of the risks identified were staffing, equipment and supplies and information technology (IT).
- Risk assessments were completed on a standard template to ensure information was consistent. Each risk had an identified risk handler and actions to reduce the risk. There were review dates for all the risks. We saw examples of clinic risk assessments and office risk assessments, all had been completed with adequate information, and updated with any additional measures taken to reduce the risk.
- The risk register was reviewed monthly by the SMT. Risk management was a standing agenda item on the governance council meeting. This was attended by the governance manager, operational lead and the designated clinic lead.
- The performance dashboard was updated and reviewed monthly by the clinic manager and governance manager. The performance dashboard recorded the number of patients scanned, number of patients that did not attend (DNA), cancellations and report turn around. Performance was monitored at a local and corporate level. Progress in delivering services was monitored through key performance indicators (KPI). Performance dashboards and reports were produced that enabled comparisons and benchmarking against other Global Diagnostic services.
- There was a business continuity policy detailing mitigation plans in the event of a number of potentially disruptive events, such as; a major accident or incident, national disaster, terrorist attack, fire, flood, extreme weather conditions, loss of utilities, including IT and telephone systems, major disruption to staffing and a cyber-attack on IT system.

Managing information

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- The service had checked systems and processes were in place for their compliance with the General Data Protection Regulation (GDPR) introduced from May 2018. The General Data Protection Regulation (GDPR) is a legal framework that sets guidelines for the collection and processing of personal information of individuals within the European Union (EU).
- Staff had access to the Global Diagnostics shared electronic drive where they could access policies and procedures.

- Staff told us there was sufficient numbers of computers in the service. This enabled staff to access electronic information when they needed to.
- The staff we spoke with could demonstrate how to locate and access relevant information and records, this enabled them to carry out their day to day roles.
- Electronic patient records could be accessed easily but were kept secure to prevent unauthorised access to data.
- Information from scans could be reviewed remotely by referring clinicians to give timely advice and interpretation of results to determine appropriate patient care.

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.**
- Staff met on a regular basis to discuss service delivery and planning. Meetings were attended by the clinic manager. We saw the minutes from the last staff meeting from 19 January 2019. The main aim of this meeting was to inform and update staff of the start date for the building of the static MRI unit and reconfiguration of the clinical and reception areas.
- The senior management had devised an innovative way of engaging with staff through "KLOE staff awards". This were based on the CQCs key lines of enquiries, looking at the domains of safe, effective, caring, responsive and well-led. Staff nomination took place on a monthly basis and included recognition of good practice for example; team work, management skills and going above and beyond for the care of their patients. Senior management team told us that these awards had been positively received by all staff.
- The SMT communicates with staff through the monthly SMT bulletin, this helped to update staff with plans from corporate level and what this could mean for staff. For example, the SMT bulletin from January 2019 announced that corporate Global Diagnostics was under new ownership. It also contained information around the development of the Norwich site.
- The governance manager told us that they planned to roll out a staff survey by the end of February 2019, to capture views about the changes that were taking place in the organisation and the major development work at the Norwich site to build the static unit.
- Patient satisfaction surveys were reviewed monthly. The patient feedback audit for November 2018 and December 2018 showed 100% of patients would recommend the service. Of those who responded, 100% were satisfied or very satisfied with the way staff greeted them and the comfort and cleanliness of the environment.
- Staff told us that patient feedback was used to improve service provision. For example, staff told us following patient feedback the service made changes to improve signage around the waiting area and how to access refreshments.
- Managers told us that they engaged regularly with clinical commissioners to understand the service they required and how services could be improved which contributed to an effective pathway for patients. They also told us they had a good relationship with local NHS providers.

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.**
- Commissioners of the service met with the provider monthly to discuss the key performance indicators where quality improvements were discussed.
- At the time of the inspection, planning and development of the Norwich site to build a fixed MRI suite and improve other clinical areas was well underway. We were told by staff that the development of the site would allow them to explore the introduction of other services that were within the remit of their registration.
- The service outsourced the quality and image quality audits to an external company. Following an increase in audit discrepancies, the clinical governance group completed a full review to provide assurance on the audit provider. Because of this work, Global Diagnostics has identified another external audit provider, that will give the service a better quality

assurance process. Managers told us that this will improve the sample size audited, have access to a pool of specialist radiologists to review specialist images and reduce staff intervention to improve efficiency.

- Global Diagnostics recently got the ISO 9001:2015 accreditation in September 2018. The ISO 9001 international standard focuses on an organisation's quality management system in place and its effectiveness.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all equipment such as wheelchairs and trollies used in the MRI unit are labelled as 'MR conditional' or 'MR safe', to indicate that these equipment were safe to use in an MR environment as per the MHRA safety guidelines for magnetic resonance imaging equipment.