Milton Keynes MRI Centre

Quality Report

The MRI Centre Unit
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Date of inspection visit: 1 October 2018
Date of publication: 06/12/2018

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

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

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

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

Summary of findings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

InHealth Milton Keynes MRI Centre is operated by InHealth Limited.

The MRI Centre at Milton Keynes University Hospital is a joint venture between a local acute NHS trust and InHealth Limited. The site was opened in 1998. The site provides a wide range of magnetic resonance imaging (MRI) scans to NHS and private patients.

The unit is the only MRI service within the acute NHS trust hospital. The unit is registered with the CQC to undertake the regulated activity of diagnostic and screening procedures. The site provides a service for both adults and paediatric patients. The site opening hours are 7am to 9pm seven days a week, also providing an out of hours on call service for emergency cases up to 11pm. site also provides an on-call service for urgent scans required out of normal working hours.

The service has one magnetic resonance imaging (MRI) scanner. The MRI Centre is a single-story building attached to the main hospital through a link corridor. The unit has its own external entrance and also offers seven parking spaces for staff and patients. The unit comprised a waiting area and reception, two offices for use of InHealth staff and a store cupboard and kitchen area. There are two patient toilet facilities, one for mixed sex and one with disabled access. The unit also houses seven offices which are used by the trust radiologists. The clinical area provides two changing rooms, one of which contains a secure storage cupboard. The controlled access area contains two bed bays and has access to the control room, plant room and scan room. The control area is accessible through a secure access door.

The service provides contracted imaging to NHS and a number of private patients.. There were 15,570 MRI scans performed at the service between August 2017 to August 2018; 15,500 of these were commissioned by a local acute trust 70 were completed as part of a NHS contract for a clinical commissioning group. 796 of the 15,570 patients scanned were under the age of 18. 61 were under one year, 107 were between the ages on one and five and 728 were between six and 18.

The service had not been the subject of an external investigation between August 2017 and August 2018.r

InHealth is not responsible for the reporting of the images for this service. The Reporting for all NHS commissioned work is completed by the NHS trust radiologists. Private work undertaken at this service is reported on by radiologists working for InHealth under practising privileges. We inspected diagnostic imaging services at this location.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 1 October 2018.

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 service provided the regulated activity of diagnostic and screening procedures.

Services we rate

We rated it as good overall following this inspection.

We found the following areas of good practice because:

- There were systems, processes and practices essential to prevent people from harm identified, put in place and communicated to staff.

Summary of findings

- The design, maintenance and use of facilities and premises were appropriate and standards of cleanliness and hygiene were maintained.
- There were sufficient numbers of staff with the necessary skills, experience and qualifications to meet patients' needs.
- Patients' individual care records were written and managed in a way that protected patients from avoidable harm.
- Patients' needs were assessed, and their care and treatment was planned and delivered in line with evidence-based guidance, standards and best practice.
- Information about the outcomes of people's care and treatment routinely collected and monitored.
- Staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, took on new responsibilities and on a continual basis.
- Patients had timely access to scanning.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.
- Staff treated patients with dignity, kindness, compassion, courtesy and respect. Staff were caring, kind and engaged appropriately with patients.
- Information about the needs of the local population was used to inform how services were planned and delivered.
- Services were planned to take account of the needs of different people, referrals were prioritised by clinical urgency.
- Leaders had the skills, knowledge, experience and integrity needed both, when they were appointed and on an ongoing basis.
- The provider had a clear vision and a set of values, with quality and safety the top priority.

However, we found areas of practice that the service needed to improve:

- Two issues noted did not meet infection prevention and control guidance. There was a sign in a changing room which had been fixed to the wall with tape. A wedge being used to position patient's legs in the MRI room was not covered with a protective cover between patients. The wedge had been covered with a pillow case: the pillowcase was changed daily and not changed between patients.
- While the service had recognised radiographers' scanning performance should be monitored through peer review to enable any issues to be discussed in a supportive environment, at the time of inspection, this had not commenced.
- Not all issues impacting on the service were on the risk register. For example, the ageing MRI scanner.
- Two protocols passed their time for review. The abdomen and pelvis protocol was due for review in July 2018 and the orthopaedic protocol was due for review in August 2018.

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

Amanda Stanford

Deputy Chief Inspector of Hospitals (Central)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	The service provided at this location was diagnostic and screening procedures. We rated this core service as good overall because it was safe, effective, caring, responsive and well-led.

Summary of findings

Contents

Good

InHealth Milton Keynes MRI Centre

Services we looked at
Diagnostic imaging

Summary of this inspection

Background to Milton Keynes MRI Centre

InHealth Milton Keynes MRI Centre is operated by InHealth Limited. The head office is location at High Wycombe, Buckinghamshire. InHealth was established over 25 years ago.

The unit provides a wide range of magnetic resonance imaging (MRI) scans examinations to the NHS, Clinical Commissioning Groups and a number of private patients. 15,570 MRI scans performed at the service between August 2017 to August 2018.

There is a registered manager (RM) in place.

Our inspection team

The team comprised a CQC lead inspector who had completed the single speciality diagnostic imaging training and a specialist advisor. The inspection team was overseen by Phil Terry, Inspection Manager and Bernadette Hanney, Head of Hospital inspection.

How we carried out this inspection

During the inspection, we visited the registered location in Milton Keynes. We spoke with six staff including, administration staff, radiographers, and senior manager. We observed seven MRI scans and engaged with patients and relatives during these procedures. During our inspection, we reviewed seven patient records.

Information about Milton Keynes MRI Centre

The location was registered to provide the following regulated activity:

- Diagnostic and screening procedures.

The MRI Centre undertakes magnetic resonance imaging (MRI) scans. All staff employed at the unit are employed by InHealth. The site opening hours are 7am to 9pm seven days a week, also providing an out of hours on call service for emergency cases up to 11pm.

The MRI Centre is a single-story building attached to the main hospital, of an acute NHS trust, through a link corridor. The unit has its own external entrance and also offers seven parking spaces for staff and patients. The unit comprised a waiting area and reception, two offices for use of InHealth staff and a store cupboard and kitchen area. There are two patient toilet facilities, one is mixed sex and one with disabled access. The unit also houses seven offices which are used by the trust radiologists. The clinical area provides two changing rooms, one of which contains a secure storage cupboard. The controlled access area contains two bed bays and has access to the control room, plant room and scan room. The control area is accessible through a secure access door.The scan room houses a single 1.5T MRI Scanner.

During the inspection, we visited the registered location in Milton Keynes. We spoke with six staff including, administration staff, radiographers, and senior manager. We observed seven MRI scans and engaged with patients and relatives during these procedures. During our inspection, we reviewed seven 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.

Summary of this inspection

The service was registered with the CQC in March 2011. We previously inspected the service in August 2013. This inspection was carried out under the previous inspection methodology. It was a routine inspection. We inspected the following standards, this is what we found:

- Consent to care and treatment. Met this standard.
- Care and welfare of people who use services. Met this standard.
- Safeguarding people who use services from abuse. Met this standard.
- Assessing and monitoring the quality of service provision. Met this standard.
- Records. Met this standard.

Activity (August 2017 to August 2018)

- There were 15,570 MRI scans performed at the service between August 2017 to August 2018; 15,500 of these were commissioned by a local acute trust. 70 were completed as part of a NHS contract for a clinical commissioning group.

The service did not use any controlled medicines and therefore they are not required to have an accountable officer for controlled drugs (CDs).

Track record on safety:

- No never events.
- No serious incidents.
- No incidences of healthcare acquired Methicillin-resistant Staphylococcus aureus (MRSA).
- No incidences of healthcare acquired Methicillin-sensitive Staphylococcus aureus (MSSA).
- No incidences of healthcare acquired Clostridium difficile (C. difficile).
- No incidences of healthcare acquired Escherichia coli (E-Coli).
- The service had received three complaints between September 2017 and September 2018, all of which were upheld.

Services accredited by a national body:

- InHealth had three accreditations by national bodies.
  - Investors in People (Gold award), awarded December 2016, date of renewal: December 2019
  - ISO 9001: Quality management systems standards, awarded 2015, Date of renewal: December 2019
  - ISO 27001: International Organization for Standardization - information security management awarded 2013, Date of renewal: December 2019

Services provided under service level agreement:

- Clinical and or non-clinical waste removal.
- Laboratory services.
- Interpreting services.
- Maintenance of medical equipment.
- Laundry.

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

We rated safe as good because:

- Staff received effective mandatory training in the safety systems, processes and practices. There was a focused and individual approach to patient care.
- There were systems, processes and practices essential to prevent people from harm identified, put in place and communicated to staff.
- Standards of cleanliness and hygiene were maintained.
- The design, maintenance and use of facilities and premises were appropriate.
- There were comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance.
- There were sufficient numbers of staff with the necessary skills, experience and qualifications to meet patients' needs.
- Patients' individual care records were written and managed in a way that protected patients from avoidable harm.
- Arrangements were in place for managing medicines, medical gases and contrast media that protected patients from avoidable harm.
- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses.

However:

- Two issues noted did not meet infection prevention and control guidance. There was a sign in a changing room which had been fixed to the wall with tape. A wedge being used to position patient's legs in the MRI room was not covered with a protective cover between patients. The wedge had been covered with a pillow case, the pillowcase was changed daily and not changed between patients.

Are services effective?

Are services effective?

We currently do not rate effective, we found:

- Patients' needs were assessed, and their care and treatment was planned and delivered in line with evidence-based guidance, standards and best practice.
- Information about the outcomes of people's care and treatment routinely collected and monitored.

Summary of this inspection

- Staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, took on new responsibilities and on a continual basis.
- All necessary staff, including those in different teams and services were involved in assessing, planning and delivering people's care and treatment.
- Patients had timely access to scanning.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.

However:

- While the service had recognised radiographers' scanning performance should be monitored through peer review to enable any issues to be discussed in a supportive environment, at the time of inspection, this had not commenced.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with dignity, kindness, compassion, courtesy and respect.
- Staff were caring, kind and engaged appropriately with patients.
- Staff understood the potential impact a patient's care, treatment or condition had on their wellbeing and on their relatives, both emotionally and socially.
- Staff recognised when patients and those close to them need additional support to help them understand and be involved in their care and treatment and enable them to access this.

Are services responsive?

Good

Are services responsive?

We rated responsive as good because:

- Information about the needs of the local population was used to inform how services were planned and delivered.
- Services were planned to take account of the needs of different people, for example, on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation.
- Referrals were prioritised by clinical urgency.
- Patients we spoke with knew how to make a complaint or raise concerns.

Are services well-led?

Good

We rated well-led as good because:

Summary of this inspection

- Leaders had the skills, knowledge, experience and integrity needed both, when they were appointed and on an ongoing basis.
- The provider had a clear vision and a set of values, with quality and safety the top priority.
- Staff told us they felt supported, respected and valued by the organisation.
- There was an effective governance framework to support the delivery of the strategy and good quality care.
- There was a risk assessment system in place locally with a process of escalation onto the corporate risk register.
- Electronic patient records were kept secure to prevent unauthorised access to data, authorised staff demonstrated they could be easily accessed when required.
- Attempts were made to gather patients' views and experiences.
- Staff could provide examples of improvements and changes made to processes based on patient feedback, incidents and staff suggestion.

However:

- Not all issues impacting on the service were on the risk register. For example, the aging MRI scanner.
- Two protocols passed their time for review. The abdomen and pelvis protocol was due for review in July 2018 and the orthopaedic protocol was due for review in August 2018.

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

Notes

We do not rate effective.

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Good

We rated this service as **good.**

Mandatory training

- Staff received effective mandatory training in the safety systems, processes and practices. At the time of inspection, 96% of staff were compliant with their mandatory training. Training was delivered in either a face to face format or as an e-learning module. A contemporaneous training record was available for all staff and was reviewed by their line manager.
- Mandatory training subjects included:
  - Fire safety and evacuation.
  - Health and safety for healthcare.
  - Equality and diversity.
  - Infection prevention and control.
  - Moving and handling objects and people/patients.
  - Customer care and complaints.
  - Basic life support (BLS) and data security awareness.
- At the time of inspection, BLS compliance for the service was 80%. However, of the six staff showing as non-compliant, four had training booked. Two of the staff's training had expired. There was a plan in place to ensure staff attended their expired training.
- It was a requirement for all qualified clinical staff to have immediate life support (ILS) training. At the time of inspection, ILS training compliance was 87%. However, both staff who were showing as non-compliant had training booked. There was a system in place to ensure there were always staff members on duty with the correct level of resuscitation training.
- The staff did not have child specific resuscitation training but all children seen in the unit were accompanied by appropriately trained staff from the acute trust.
- Bank staff used within the department were required to undertake the same mandatory training as substantive InHealth staff members. This could be provided by evidence from another source for example evidence of up to date training from their main employer, or they were able to enrol for a mandatory training course run by InHealth.

Safeguarding

- There were systems, processes and practices essential to prevent people from harm identified, put in place and communicated to staff.
- The lead for safeguarding was the nominated individual who was trained to level four.
- Staff were trained to recognise adults at risk and were supported with an effective safeguarding adults' policy in place that reflect relevant legislation and local requirements. Staff we spoke with demonstrated they understood their responsibilities and adhered to safeguarding policies and procedures.
- At the time of the inspection, 97% staff had been trained safeguarding children level one and two and safeguarding adults. The unit treated patients who were under the age of 18. 97% staff had received training in safeguarding children and young people level two. There was a system in place to ensure there were always staff members on duty with the correct level of safeguarding training. Staff had access to the safeguarding team based at the acute hospital. Patients under the age of 18 who attended the service out of hours were always accompanied by a member of staff with the correct training from the acute trust. This met

intercollegiate guidance 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff '(March 2014). Guidance states all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers should be trained to level two.
- Contact numbers for local adult and child safeguarding referrals were displayed in the magnetic resonance imaging (MRI) control room and in staff offices.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were maintained. InHealth Limited had infection prevention and control (IPC) policies and procedures in place which provided staff with guidance on appropriate IPC practice in for example, communicable diseases and isolation.
- There had been no instances of healthcare acquired infections between September 2017 and September 2018.
- All areas we visited on the day of inspection were visibly clean and generally clutter free. At the time of inspection, the service was in the process of being repaired and redecorated following a recent flood. The maintenance work was being managed in a way that ensured it did not impact on the patients using the service.
- The unit team cleaned the MRI scan room at the end of each day. Cleaning was recorded on a daily check sheet which was reviewed by the unit superintendent each week.
- We observed staff to be compliant with best practice regarding hand hygiene, and staff were noted to be bare below the elbow. There was access to hand washing facilities. We observed staff washing their hands using correct hand hygiene techniques before, during and after patient contact. Patients told us staff always washed their hands prior to attending to them. Hand sanitiser gels were available at the entrances to all rooms. Information charts about hand hygiene were displayed throughout the clinical areas we visited.
- Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO) 'Five Moments for Hand Hygiene.' These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene to reduce risk of cross contamination between patients. Results for May 2018 to July 2018 showed a compliance rate of 93%. Hand hygiene results were communicated to staff through their staff meetings and through email. Training was provided to staff requiring improvement on their technique.
- A supply of personal protective equipment (PPE), which included gloves and aprons were available and accessible in all clinical areas. During this inspection we observed all staff to be using PPE appropriately.
- Staff followed manufacturer's and IPC guidance for routine disinfection. Staff cleaned most medical devices, including MRI coils between each patient and at the end of each day. We observed staff cleaning equipment and machines during this inspection. However, we observed a wedge, used to position patient's legs in the MRI room. The wedge had been covered with a pillow case, the pillowcase was changed daily and not changed between patients. It was not covered with a protective cover between patients. This did not did not meet infection prevention and control guidance. We raised with staff at the time of the inspection and manager reminded staff to ensure a protective cover was used and replaced between each patient.
- Staff adhered to National Institute for Health and Care Excellence (NICE) QS61 Statement 5, 'People who need a vascular access device have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the device and its removal'.
- Staff were trained in cannulation and explained to us the need to monitor cannula sites for extravasation. Staff told us the about process, they removed the cannula promptly post scan and disposed of it correctly in a contaminated sharps container. Cannulas were left in situ for ten mins after injection of contrast in case the patient should experience a delayed contrast reaction. We observed safe practice.
- Sharps disposal bins (secure boxes for disposing of used needles) were located as appropriate across the service which ensured the safe disposal of sharps, for example needles. They were all clean and not overfilled. Labels were correctly completed to inform staff when the sharps disposal bin had been opened.

Environment and equipment

- The design, maintenance and use of facilities and premises were appropriate. The layout of the unit was compatible with Health Building Note (HBN06) guidance.

Good

Diagnostic imaging

- The building had clear signage and visual prompts to assist with patients and visitors attending the service. Access to the MRI area was secure with doors opened through a key fob entry system.
- The unit had its own external entrance and also offered seven parking spaces for staff and patients. The unit comprised, a waiting area and reception, two offices for use of InHealth staff and a store cupboard and kitchen area. There were two patient toilet facilities, one was accessible for people with disabilities. The unit also had seven offices which were used by acute trust radiologists. At the time of inspection, most of these offices were being redecorated following a recent flood. Trust radiologists were using alternative offices.
- The clinical area provided two changing rooms, one of which, contained a secure storage cupboard. The controlled access area contains two bed bays and has access to the control room, plant room and scan room. The control area is accessible through a secure access door.
- The service had a single 1.5T MRI Scanner. A control/ observation area allowed visibility of the patient during their MRI scan. Fringe fields were displayed (The fringe field is the peripheral magnetic field outside of the magnet core. Depending on the design of the magnet and the room a moderately large fringe field may extend for several meters around, above, and below an MRI scanner).
- There was an effective system for recording faulty equipment. All machine faults were recorded by the manager, servicing of faulty MRI machines carried out under the service level agreement..
- There was sufficient space around the scanner for staff to move and for scans to be carried out safely. During scanning, patients were provided with an emergency call buzzer, ear plugs and defenders through which music could be played. A microphone allowed contact between the radiographer and the patient at all times.
- The room was equipped with an oxygen monitor, as recommended in HBN06-13.64, to ensure that any helium gas leaking (quench) from the cryogenic Dewar (this is a specialised type of vacuum flask used for storing cryogens such as liquid nitrogen or liquid helium), is not moving into the examination room, thus displacing the oxygen and compromising patient safety. In addition, the room was fitted with an emergency quench switch which was protected against accidental use. The magnet was also fitted with emergency “off” switches, which suspend scanning and switch off power to the magnet sub-system but will not quench the magnet. Staff we spoke with were fully aware of the emergency nature of a quench situation.
- Two MRI safe wheelchairs and trolley were available in the scanning room should they be required to transfer a patient in the event of an emergency.
- Patient weighing scales were available in the unit and we saw where they had been appropriately service tested.
- There were procedures in place for the management of a deteriorating or collapsed patient. The service did not have resuscitation equipment, for use in an emergency in the department; however, this was accessible from the radiology department next door or from the emergency department nearby. The service carried out regular test calls to practice emergency procedures and ensure resuscitation equipment would arrive in the department in a timely manner.
- Emergency pull cords were available in areas where patients were left alone, such as toilets and changing areas. Call bells were available within the MRI scanner which patients could press if they wanted the scan to stop.
- Maintenance and use of equipment was effective. We looked at eight items of equipment; they all had a sticker indicating when they had been last serviced and when the next service was due. Equipment we looked at had an up to date service record which provided information on when an item was due to be serviced.
- We saw radiation warning signs and lights were correctly located outside the clinical diagnostic imaging area. The sign on the door, explained the magnet strength and safety rules.
- The MRI equipment was labelled in line with Medicines and Healthcare Products Regulatory Agency (MHRA) recommendations e.g. ‘MR Safe, MR Conditional, MR Unsafe’. For example, in the assessment area all equipment not suitable to be used in the MRI room was labelled MR unsafe.
- There were appropriate arrangements for managing waste and clinical specimens. Dirty linen and equipment was kept separately. Clinical waste bins were foot operated and once bags were full, they were removed to a secured waste area.
- Chemical products deemed as hazardous to health were in locked cupboards or rooms that were only accessible to authorised staff.

- Spills kits, for the safe cleaning of body fluids, such as blood were readily available.
- 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.

Assessing and responding to patient risk

- There were comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance. For example, we saw evidence of a magnetic resonance imaging patient safety questionnaire. Risks were managed positively and updated appropriately where a change in the patient's condition was required for example managing the claustrophobic patient.
- Staff used the Society of Radiographers (SoR) "Paused and Checked" system. To reduce the risk of referrer error. Pause and Check consisted of the three-point demographic checks to correctly identify the patient, as well as checking with the patient the site/side to be imaged, the existence of previous imaging and for the operator to ensure that the correct imaging modality is used.
- Clinical staff told us they felt confident to identify and respond appropriately to changing risks to people who use services, including deteriorating health and wellbeing or medical emergencies. 87% of clinical staff had received immediate life support training. There were pathways and processes for staff to assess people using services who were clinically unwell and need hospital admission. For example, the InHealth routine MRI guidance policy was available to guide staff in referring patients to an accident and emergency (A&E). We did noted that there were two policies for staff to follow:
  - 1) management of minor drug reactions of MRI patients to A&E V001,
  - 2) Administration of gadolinium-based contrast media policy V007.
- Patients that became unwell in the unit would be initially reviewed on site by the doctor if in attendance or referred to their GP. However, if the patient required more urgent treatment, they would call the crash team or the emergency department.
- No patients were transferred from the location to another health care provider from September 2017 and September 2018.
- The service ensured that the 'requesting' of an MRI was only made by staff in accordance with MHRA guidance (Safety Guidelines for Magnetic Resonance Imaging Equipment in Clinical Use) (2015). The referral forms included patient identification, contact details, clinical history and examination requested, and details of the referring clinician/practitioner.
- Signs were in the waiting area and changing rooms highlighting the contraindications to MRI including pacemakers. Signs also informed patients and visitors of the magnet strength and that it was always on.
- There was a pathway for unexpected urgent clinical findings. Staff we spoke with explained the processes to escalate unexpected or significant findings both at the examination and upon reporting. The urgent report was sent to the referrer, the administration team contact the referrer to confirm receipt. These were in line with the InHealth routine MRI guidance policy. For example, if the patient needed urgent report and an attendance at A&E following scan findings, an urgent report request was sent to the reporting provider. Once the report was received (within 24 hours), an email was sent to the agreed staff within the referring trust to highlight an urgent report. In addition to this, InHealth's Picture Archiving and Communication System (PACS) team also contacted the referrer by phone to inform them an urgent report had been sent and the person who was spoken to was recorded on the database. They were asked to verbally acknowledge that an email with the report had been received. If the patient was a private patient, the reporting radiologist was contacted by a member of staff to advise them an urgent report was required to ensure it received prompt attention .If at time of scan, the radiographers thought the patient needed urgent medical attention, the patient was advised to attend A&E. All images would be sent to A&E urgently through the image exchange portal to assist in patient management.
- There were robust pregnancy checking procedures in place. Radiographers checked the status of all women of childbearing age prior to examination. There was also clear signage within the department waiting areas and changing cubicles to ask patients to let staff know if there was a possibility that they were pregnant. The service audited compliance of these checks.
- We saw evidence the potential risks of intravascular administration of contrast were weighed against the potential benefits. Systems were in place including

trained individuals that were able to recognise and treat severe contrast reactions, including anaphylaxis. At the service this role was fulfilled by radiographer who had been appropriately trained. A doctor was always present in the location when contrast was administered. This maybe in some cases in another department within the hospital trust.

- There were local policies in place for the risk assessment and prevention of contrast-induced nephropathy. There were in keeping with the National Institute for Health and Care Excellence (NICE) acute kidney injury (AKI) guidelines and the Royal College of Radiologists (RCR) standards for intravascular contrast agent administration.
- There was a policy for documenting, investigating, making a referral to a specialist drug allergy service and advising the patient in cases where significant suspected contrast reactions were suspected.
- Staff were provided with a debrief, or other support after involvement in any incident/accidents.

Staffing

Radiography staffing

- There were sufficient numbers of staff with the necessary skills, experience and qualifications to meet patients' needs. An InHealth staffing policy was in place; this enabled the unit to effectively maintain safe staffing levels and ensured there were sufficient numbers of suitably qualified, skilled staff to carry out daily tasks. The policy and procedure outlined how the headcount (actual number of staff on duty) and full time equivalent (FTE) numbers were to be calculated and managed at unit level.
- The staffing policy ensured the service operated safely and effectively, with the appropriate number of staff and correct skill mix levels required to facilitate safe and compassionate care. The service used a purpose built 'staffing calculator', designed to take account of expected, and a degree of unexpected, absences; They used this to ensure sufficient staff were available across all operational periods. Required staffing levels were calculated using core service information including:
  - Operational hours.
  - Patient complexity and service specifications.
  - Physical layout and design of facility/service -Expected activities.
  - Training requirements.
- The service employed two whole time equivalent (WTE) superintendent radiographers five and half WTE senior radiographers, two WTE radiographers and six WTE radiographic assistants. Staff worked across two InHealth diagnostic services based in Milton Keynes.
- Since August 2017, one WTE senior radiographer had left the service, one WTE senior radiographer had joined the service. Four administrators had left the service, three had joined the service. One senior administrator had left the service.
- At the time of inspection, the service had the following vacancies:
  - One WTE senior radiographer.
  - One senior administrator.
  - One administrator (fixed term to cover maternity leave).
- The service had used bank staff to cover times of staff shortage. Between June 2018 and August 2018, one senior radiographer shift, 51 radiographic assistant shifts and 70 administrator shifts were covered by bank staff. 36 senior radiographer shifts were covered by InHealth senior radiographers brought in from other locations.
- Between June 2017 and August 2018, the average sickness rate was reported as 17.8% for senior radiographers and 2.2% for administrators.
- The unit manager was also the manager for another InHealth diagnostic unit locally and flexed regular radiographer cover across both units to cover days off and leave. The staffing team for Milton Keynes Hospital MRI Centre also covered Milton Keynes InHealth Diagnostic Centre.
- This ensured staff continuity and familiarity with the unit. Most staff rotated between both services.
- All staff we spoke with felt that staffing was managed appropriately. There had been no appointments cancelled due to staffing between August 2017 and August 2018.
- Radiographers told us they could contact a manager for advice at any time. There was an on-call provision: the superintendents and registered manger shared the on-call responsibilities.
- While the service had not used agency staff within the service between August 2017 and August 2018, the service had a policy in place to support agency staff. On first day within the department, all new staff, including bank, agency staff and contractors were taken through the companies' Induction Checklist. They were also

asked to complete a local induction which detailed the department, emergency procedures, checks that were completed on a daily/ weekly basis, local and companywide policies and procedures, local rules and guidance and any access to system which may be required should the staff member be working with the unit for a few weeks. The unit superintendent or imaging services manager provided them with a tour of the department. The staff member was given relevant contact numbers which may be required during a normal working day and emergency contact details of the imaging service manager should they not be on site. The agency staff member would always be working with an experienced member of InHealth staff. Prior to undertaking any shifts independently, the agency or bank staff member would have to successfully complete a period of induction. Prior to any agency staff member being employed to assist in an uncovered shift, the imaging services manager for the unit reviewed the candidates references from previous employers or site they have worked as agency and proof of all compulsory mandatory training relevant to the position they were required to fill, and previous equipment experience to establish suitability.

- Each service was managed by an experienced operational manager, supported by regional management and central support functions, to maintain 24-hour accountability for safe and appropriate staffing levels.
- The service had a 'lone working' policy and risk assessment process.
- The service had a comprehensive business continuity plan detailing mitigation plans in the event of unexpected staff shortages or unavailability.

Medical staffing

- The service did not employ any medical staff. All consultants worked for the local NHS trust.

Records

- Patients' individual care records were written and managed in a way that protected patients from avoidable harm. We reviewed seven patient records. Records were accurate, complete, legible, up to date and stored securely. Records were electronic and available for access by staff. Paper records such as paper referrals were shredded as per policy once the information was uploaded.
- The Radiology Information System and Picture Archiving and Communication System used by the service was secure and password protected. Each staff member had their own personally identifiable password.
- The service provided electronic access to diagnostic results to the referring hospital and could share information electronically if referring to an A&E for emergency review.
- We could not see any evidence that the quality of images were being peer reviewed locally or quality assured on a corporate level. There was a risk any deficiencies in images would not be highlighted to the member of staff for their learning. However, there was a plan for the service to start this audit within the next few months.
- The provider communicated with the patient's GP when necessary for example, following unexpected urgent clinical findings. If the patient needed urgent report and an attendance at A&E following scan findings, an urgent report request was sent to the reporting provider. Where an urgent report is required, an urgent report request was sent to the reporting provider for all referral types. Once the report was received (within 24 hours), an email was sent to the agreed staff within the referring trust to highlight an urgent report. InHealth administration staff also contacted the referrer by phone to inform them of an urgent report.

Medicines

- Arrangements were in place for managing medicines, medical gases and contrast media that protected patients from avoidable harm. This included obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal.
- Medicines, including intravenous fluids, were stored securely. Medicines requiring storage within a designated room were stored at the correct temperatures, in line with the manufacturers' recommendations, to ensure they would be fit for use.
- Room temperatures were recorded as part of the daily checks by staff. The temperature records showed temperatures had been checked daily and were within the required range. Staff knew what to do if the temperatures were not within the required range. This would be escalated to the unit manager, or manager on

call if out of hours and the service company would be contacted. Staff understood the process for reducing the life of medications if temperature had not been maintained.

- No controlled drugs were stored and/or administered as part of the services provided in this unit. Controlled medicines are classified (by law) based on their benefit when used in medical treatment and their harm if misused. The Misuse of Drugs Regulations include five schedules that classify all controlled medicines and drugs.
- Patient Group Directions (PGDs) were used in the service. PGD's were in place for all commonly used gadolinium-based contrast agents. PGDs were also in place for intravenous injections of anti-stomach cramp medicines, saline and administration of oxygen.
- The Society of Radiographers (SoR) recommended "Paused and Checked" system was used to check medications prior to administration.
- Staff were trained on the safe administration of contrast media including intravenous contrast (IC). We reviewed staff competency files and saw all staff had received this training. We observed one patient receiving IC during our inspection; their allergies were documented and checked on arrival in the unit.
- Emergency medicines were available in the event of an anaphylactic reaction. We checked this medication and it was in date.
- Patients were given a patient information card post scan which documented which medications they had been given. This included contrast media, bowel preparations and anti-spasmodics. The card directed patients to seek advice from their GP or A&E if feeling unwell after leaving the unit and explained they should show the information regarding what they had received.
- The pharmacy team at the acute trust was available for assistance and advice locally if required. InHealth had a consultant pharmacist who issued guidance and support at a corporate level and worked collaboratively with the InHealth clinical quality team on all issues related to medicines management. Replacement medication and disposal was provided by this service.

Incidents

- There were no never events reported for the service from September 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.
- There were no serious incidents reported for the service from September 2017 to September 2018 as defined by the NHS improvement serious incident framework 2013. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.
- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses. Staff reported incidents using an electronic reporting system. The service had an incident reporting policy and procedure in place to guide staff in the process of reporting incidents. The service had recorded 90 incidents from August 2017 to August 2018. 22 incidents were graded as low risk, 54 incidents were graded as moderate risk and 14 incidents were graded as high risk. There were eight common trends, abuse/harassment, booking issues, breach of confidentiality, clinical incident, equipment incident, health and safety incident, MRI incident, report related incidents and safeguarding.
- All incidents and complaints reported through the organisations electronic risk management system were reviewed on a weekly basis within the 'complaints, litigation, incidents and compliments (CLIC)' group by a multi professional team of governance and operational managers. Incidents involving patient or service user harm were assessed against the 'notifiable safety incident' criteria as defined within regulation 20 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. Incidents that met this threshold were managed under the organisations 'adverse events (incident) reporting and management policy' and 'Duty of Candour, procedure for the notification of a notifiable safety incident' standard operating procedure. Decisions relating to organisational disclosures made both under the statutory duty of candour framework and in the wider spirit of openness and transparency were recorded within the corresponding incident or complaint record and held within the electronic risk management system. The duty of candour is a regulatory duty that relates to openness and

transparency and requires providers of health and social care services to notify patients (or other relevant persons) of any unintended or unexpected incident and provide reasonable support to that person.

- From reviewing the incident log, we could see staff reported incidents as per policy for example, staff had reported errors in the booking process, any concerns about pathway delays, and confidentiality. There were thorough investigations, and all relevant staff had been involved in the review or investigation. We saw the service looked for opportunities to learn lessons from these incidents with staff attending additional training and learning being shared at staff meetings for example in response to a booking issues, improved appointment letters were devised with more detailed information for the patient were implemented.
- Staff used SoR "Paused and Checked" system. Referrer error was identified as one of the main causes of incidents in diagnostic radiology, attributed to 24.2% of the incidents reported to the CQC in 2014. The six-point check had been recommended to help combat these errors. Pause and Check consisted of the three-point demographic checks to correctly identify the patient, as well as checking with the patient the site/side to be imaged, the existence of previous imaging and for the operator to ensure that the correct imaging modality is used.
- Relevant national patient safety alerts were communicated by email to all staff. All staff had to accept emails with mandatory information in them this evidenced that they had been read.
- There were local procedures in place, which were being followed to ensure where there had been critical, urgent and unexpected significant radiological findings, the radiologist produced reports as quickly and efficiently as possible, the requesting doctor and/or their clinical team to read, and act upon the report findings as quickly and efficiently as possible

Safety Thermometer (or equivalent)

- The service did not complete the safety thermometer as this was not applicable to the service they provided their patients.
- The service maintained on a unit level performance dashboard. This was updated daily and reviewed monthly by the manager and superintendent radiographer. The dashboard indicated the number of patients scanned, number of parts scanned, number of patients that did not attend, cancellations and feedback forms completed.
- The service recorded and reviewed daily safety checks, for example: emergency buzzer, intercom, temperature and air conditioning and unit emails.
- The performance dashboard and daily check were reviewed at least weekly and an action plan was used to monitor any omissions or concerns.

Are diagnostic imaging services effective?

We do not rate effective.

Evidence-based care and treatment

- Patients' needs were assessed, and their care and treatment was planned and delivered in line with evidence-based guidance, standards and best practice. Relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment were delivered, for example: National Institute for Health and Care Excellence (NICE) CG68 'Stroke and transient ischaemic attack in over 16s: diagnosis and initial management', NICE CG75 'Metastatic spinal cord compression in adults'.
- We saw no evidence of any discrimination, including on grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation when making care and treatment decisions.
- At the time of inspection, the service did not audit the work undertaken by on site radiographers. We saw the service had planned to begin to audit of 10% of the total number reported. However, this audit had not commenced.

Nutrition and hydration

- There were no nutrition services for patients that attended the service. However, staff had access to a selection of refreshments (tea, coffee and water) which they provided to patients.

Pain relief

- Patients were asked by staff if they were comfortable during their appointment; however, no formal pain level monitoring was carried out as the procedures undertaken were pain free.

Patient outcomes

- Information about the outcomes of people's care and treatment was routinely collected and monitored.
- The service recorded the time between when a referral to the service for a scan was received and that scan being booked. Between August 2017 and July 2018 98% patients on the two week wait target were seen in two weeks, 98% of the urgent patients were seen within two weeks. 84% of the routine patients were seen within their target of four weeks and 99% of routine patients were seen within their target of 39 days.
- Staff audited and compared key elements of the referral and scanning pathway and these were benchmarked with other InHealth locations.
- Audits of the quality of the images were not undertaken by the provider. The acute trust consultants were responsible for the reporting and analysis of images. This was not monitored or audited by InHealth.
- The service had an audit schedule. The audits aimed to assist in monitoring the service and drive improvement. It involved all staff ensuring they had ownership of things that had gone well and that needed to be improved. Audits included hand hygiene, health and safety and patient experience.
- The service submitted a monthly report to the radiology services manager, this provided the trust with information on activity and any issues impacting on service provision such as staffing, equipment, operational issues and improvements.

Competent staff

- Staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, took on new responsibilities and on a continual basis. Staff had regular meetings with their manager and a performance appraisal biannually to set goals to review them.
- At the time of inspection, all eligible staff (15) had received an appraisal in the last year.
- All eligible staff (nine) had their revalidated professional registration in the last 12 months.
- Assurance of staff competence to perform their role within InHealth was assessed as part of the recruitment process, at induction, through probation, and then ongoing as part of staff performance management and the InHealth appraisal and personal development processes.
- Radiographers were Health and Care Professions Council (HCPC) registered and met the standards to ensure delivery of safe and effective services to patients. The HCPC is a regulator, set up to protect the public. They keep a register of health and care professionals who meet HCPC standards for their training, professional skills, behaviour and health.
- As part of the interview process, key attributes to ensure staff suitability were assessed These were based on predetermined questioning that aligned with the service's core values.
- Site orientation for all staff ensured their competency to perform their required role within their specified local area. For clinical staff, this was supported by a comprehensive competency assessment toolkit which covered key areas applicable across all roles, and then clinical competency skills relevant to their job role and experience. For staff joining with experience, this was completed within the probation period. Those who were newly qualified or undertaking training a new modality, this was completed as the competency was acquired.
- InHealth had developed a comprehensive internal training programme for MRI aimed at developing MRI specific competence following qualification as a radiographer.
- In the event of any aspect of competency falling short of the required standard, the practitioners' line manager was responsible for providing necessary support and guidance required to attain the relevant standard.
- Ongoing staff competence was managed through the performance review process, for example following a complaint or incidents, that highlighted potential failings and where different staff members may need support and development. Extra training was provided.
- Clinical staff were required to complete continued professional development (CPD) to meet their professional body requirements.
- The service operated a comprehensive mandatory and statutory training programme which ensured relevant knowledge and competence was maintained and updated throughout their employment with the organisation.
- The service had recognised radiographers' scanning performance should be monitored through peer review

to enable any issues to be discussed in a supportive environment. This practice would enable the reviewer to feed back any perceived issues with scanning to enhance and learning or improvements in individual performance. However, at the time of inspection, this had not commenced however a plan was in place to introduce this in the coming month.

- The service was committed to the continuing development of staff. Staff told us they were offered access to both internal and externally part funded training programmes and apprenticeships to support them in developing skills and competencies relevant to their career with InHealth.

Multidisciplinary working

- All necessary staff, including those in different teams and services were involved in assessing, planning and delivering people's care and treatment. Staff based within the service worked closely with the referring NHS trust, this ensured a smooth pathway for patients.
- Staff working in the service had good relationships with external partners and undertook scans for a local NHS provider. We saw good communication between services, staff contacted refers for advice and support, when necessary.
- The acute trust consultant radiologist report analysis, was undertaken externally to InHealth. However, multidisciplinary team meetings were held each week between the radiologists and radiographers to discuss procedure outcomes and the onward referral of care.

Seven-day services

- The site opening hours were 7am to 9pm seven days a week, also providing an out of hours on call service for emergency cases up to 11pm.
- The department also provided an on-call out of hours service for conditions that required immediate attention for example suspected cord equina. Cord equina is a bundle of spinal nerves and spinal nerve rootlets, consisting of the second through fifth lumbar nerve pairs, the first through fifth sacral nerve pairs, and the coccygeal nerve, all of which arise from the lumbar enlargement and the conus medullaris of the spinal cord. Cauda equina syndrome requires immediate medical attention to prevent physical and neurological problems. An emergency patient would be authorised by a consultant radiologist. They would be accompanied by an appropriate medical professional (a doctor or nurse).
- A senior manager was available in an on-call capacity out of usual office working hours.

Health promotion

- Information leaflets such as 'understanding your MRI scan' were sent to patients with their appointment letters and were available in the waiting rooms. Leaflets included information about what the scan would entail and what was expected of the patient before and after the scan appointment.
- Health promotion information leaflets and posters on subjects such as smoking cessation services and information on living with dementia, stroke and cancer were on display in the waiting room. The service also provided a range of information leaflets for patients and relatives, including dementia UK, deep vein thrombosis, and physiotherapy services which patients could take away.

Consent and Mental Capacity Act

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. Staff had received training on mental capacity. They were aware of what to do if they had concerns about a patient and their ability to consent to the scan. They were familiar with processes such as best interest decisions.
- Consent for MRI patients was taken on the day of the procedure. Part of the consent included asking women for their pregnancy status and checking that the procedure had been justified for women who were past the first trimester in accordance with the Medicines and Healthcare Products Regulatory Agency) safety guidelines for magnetic resonance imaging equipment in clinical use (2015).
- Staff told us if a patient lacked capacity to make decisions in relation to consenting to treatment, for example a person living with dementia attended the service, they would be encouraged to attend with a relative or carer who held power of attorney for health after they have been screened for safety to provide the necessary support.

Good

Diagnostic imaging

- MRI scans were consented for appropriately. Patient care records we reviewed included a consent to treatment record. We observed staff obtaining verbal consent from the patients during their interventions. Scan safety consent forms were completed by all patients prior to their scan, to record the patients' consent. These also contained patient's answers to safety screening.
- A corporate consent policy was available to staff. It was written in line with national guidance.
- The staff we spoke with were aware of the need for consent and gave patients the option of withdrawing their consent and stopping the scan at any time. Patients we spoke confirmed their consent had been obtained throughout the scanning process.

Are diagnostic imaging services caring?

Good

We rated this service as **good.**

Compassionate care

- Staff treated patients with dignity, kindness, compassion, courtesy and respect. We observed staff introducing themselves to patients prior to the start of an intervention. They interacted well with patients.
- Staff understood the need to respect patient's personal, cultural, social and religious needs, and they took these into account.
- Care observed met National Institute for Health and Care Excellence (NICE) QS15 Statement 1: 'Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty', NICE QS15 Statement 2: 'Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills', NICE QS15 Statement 3: 'Patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team'. NICE QS15 Statement 13: 'Patients' preferences for sharing information with their partner, family members and/or carers are established, respected and reviewed throughout their care'. Staff took the time to talk with patients and those close to them. We observed these interactions to be in a respectful and considerate manner. They showed a sensitive and supportive attitude to patients and those close to them. We saw staff take time to provide support to a patient who was a bit anxious about entering the scan.
- We spoke with five patients, all said they were happy with the service they had received. No concerns were raised. One patient described the service as very professional, another as efficiently run. All patients said the staff were friendly and helpful. Patients said they were treated with respect, care, compassion and respect. Patients told us efforts had been made to maintain patients' dignity.
- InHealth gave every patient the opportunity to complete the NHS Friends and Family Test (FFT) and indicate their likelihood to recommend the service. There was an opportunity to add free text comments on any positive or negative aspects. The FFT process used a paper-based form complete with website address so that patients may choose to complete it digitally on a personal device. The results were collated by an external provider and delivered to service managers through the InHealth intranet weekly and through a web-based dashboard accessible to all managers and staff. Service managers reviewed the results which summarised response rates (23.5% for this location) and overall likelihood to recommend (currently 97%+) and unlikely to recommend (currently 1%). The free text comments were interrogated to enable positive staff feedback and individuals could be praised where they were noted for the quality of care delivered. Negative comments were scrutinised for opportunities to drive improvement in the service.

Emotional support

- Staff understood the potential impact a patient's care, treatment or condition had on their wellbeing and on their relatives, both emotionally and socially. Staff ensured they took time to speak to patients making sure that patients privacy and dignity was observed.
- Staff were aware patients attending the service may feelnervous and anxious. We observed staff providing reassurance and support to patients. Staff were calm and reassuring in all interactions with patients at all stages, from booking in and during the scan.
- Staff saw providing support to patients and those close to them as an important part of their job. We saw staff

taking time to talk over concerns with a patient and ensuring it was appropriate for them to leave the service and travel home. Staff signposted patients to other services appropriately if necessary.

Understanding and involvement of patients and those close to them

- Staff recognised when patients and those close to them need additional support to help them understand and be involved in their care and treatment and enable them to access this. This included, for example, access to language interpreters, sign language interpreters, specialist advice or advocates. We observed staff communicating with patients so that they understood their care, treatment and condition.
- Staff made sure that patients and those close to them, felt able to ask questions about their care and treatment. They gave patients time to ask questions.
- The service enabled a parent/family member or carer to remain with the patient for their scan if this was necessary after they have been screened for safety to provide the necessary support.

Are diagnostic imaging services responsive?

Good

We rated this service as **good**

Service delivery to meet the needs of local people

- Information about the needs of the local population was used to inform how services were planned and delivered. The service provided MRI scanning for the local NHS trust, the local clinical commissioning group (CCG) and a number of private patients. The unit provided services through contractual agreements.
- Progress in delivering services against the contractual agreement was monitored by the NHS trust and CCG. Monitoring was reported through monthly contract review meetings with the acute trust, and measurement of quality outcomes for example, the patient experience. Service improvements were agreed at these regular meetings.
- The service was open seven days a week between the hours of 7am and 9pm. The department also provided an on call out of hours service for emergencies up to 11pm. The extended opening hours gave patients a greater choice of appointment times and as a result had assisted in reduced waiting time for examinations.
- The service provided services for a range of patients. The service had access to a hoist, patients who had been referred to another InHealth service locally but whose mobility required a hoist were referred to this service. Staff were confident and competent assisting patients who required assistance with their mobility.
- The service was accessible, it was on an established bus route and the train station was a short distance away. There was accessible car parking, outside the service, there were seven free designated parking spaces. Additional parking was available in a multi storey car park within a three-minute walk. However, parking costs were applicable for this additional parking.
- The facilities and premises were appropriate for the services that were planned and delivered. There was sufficient comfortable seating, toilets changing rooms and a water fountain. Additional drinks and snack were available in the attached main hospital building.
- Information was provided to patients in accessible formats before appointments. Appointment letters containing information required by the patient such as contact details, a map and directions, health professional's name if appropriate, and information about any tests or intervention including any if samples or preparation such as fasting was required. The appointments letters were sent out, asked patients to call in if they had any queries or if they had answered yes to any of the questions on the MR safety questionnaire.
- All appointments were confirmed two days prior to patient's appointment, by phone. This helped reduce the number of do not attend (DNA's) and provided an opportunity for the patient to ask us any questions they may have. Should a patient not be verbally contacted prior to their appointment, for example where a message is left for the patient on an answer machine, the patient was asked to call the service to confirm their intention to attend the appointment.

Meeting people's individual needs

- Services were planned to take account of the needs of different people, for example, on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual

orientation. Staff had received training in equality and diversity and had a good understanding of cultural, social and religious needs of the patient and demonstrated these values in their work.

- Reasonable adjustments were made so disabled patients could access and use services on an equal basis to others. All patients were encouraged in the appointment letter, to contact the unit if they had any needs, concerns or questions about their examination.
- The service provided imaging for both in patients and outpatients. The MRI scanner was on the ground floor, so it was accessible for all patients. There was an accessible disabled toilet in the building.
- Two MRI compatible wheelchairs and a trolley were available should any patients be unable to mobilise independently from the waiting area to the MRI room. A hoist was available for patients that required one.
- Interpreters could be provided if the service was informed prior to the appointment. Staff also had access to language line, a phone translation service where appropriate. In a clinical emergency. InHealth policy enabled staff to use a family member to translate at the radiographers' discretion.
- The service engaged with patients who were vulnerable and took actions to remove barriers when they found it hard to access or use services. For example, patients could visit the unit prior to their appointment, so they could familiarise themselves with the room and the scanner. This was offered to patients who had informed the service that they were nervous, anxious or phobic to try to assist them to manage their anxieties.
- The service provided MRI scan appointments for children. The service offered children colouring books that had child friendly information about the scan and what to expect. Staff had decorated one of the changing areas to make it more child friendly. Picture stickers of the characters from the colouring book had been used in the decorated changing room. Children could be accompanied by a family member/carer and could visit the unit prior to their appointment, so they could familiarise themselves with the environment.
- Children under the age of five were sedated prior to attending the service. Children were always accompanied by a suitably trained nurse. The patient remained a patient of the paediatric ward throughout their time in the service.
- Staff provided patients with information leaflets and written information to explain their condition.
- During the MRI scan, staff made patients comfortable with padding aids, ear plugs and ear defenders to reduce noise. Patients were given an emergency call buzzer to allow them to communicate with staff should they wish. Microphones were built into the scanner to enable two-way conversation between the radiographer and the patient. Patients could bring in their own music for relaxation.

Access and flow

- Patients had timely access to scanning. The service was open seven days a week between the hours of 7am and 9pm. The department also provided an on call out of hours service for emergencies up to 11pm
- Referrals were prioritised by clinical urgency. If patient symptoms were deemed to be clinically urgent, these patients were often given an appointment within eight to 24 hours depending on the urgency. All two-week cancer pathway patients were scanned within eleven days to enable report turn around. Where several clinically urgent requests were received, advice was sought from a radiologist on the priority order for booking.
- The service held slots to allow for any clinically urgent referrals, if these were not filled by urgent cases, the service utilised these appointments for in-patients or out patients who could be contacted and attend at short notice.
- Should the need arise to add an urgent referral into the waiting list when no appointments were available, the unit would assess appointments filled by routine, not urgent examinations and rebook patients to make room for the clinical urgent case. The rebooked patient would be given the next available appointment to suit the patient.
- Between October 2017 to September 2018, 71 planned procedures/examinations were cancelled for a non-clinical reason. 59 cancellations were due to machine breakdown or other equipment failure, this was the most common reason for cancellations.
- No planned procedures/examinations were delayed for a non-clinical reason between October 2017 to September 2018.
- Appointments generally ran to time; reception staff would advise patients of any delays as they signed in. Staff would keep patients informed of any ongoing delays. Staff would also place a notice board in the waiting area detailing the time of delay.

Good

Diagnostic imaging

- The service submitted a monthly report to the radiology services manager at the acute trust to advise them of any issues. The report covered subjects such as staffing, activity, any issues with equipment, operational issues and improvements.
- As reporting on scans was carried out by the trust radiologists the service did not officially report on reporting times. However, the service told us typically inpatients' scans were reported on within 24 hours, and urgent out-patients' scans were reported on within 48 hours. This met national guidance.

Learning from complaints and concerns

- Patients we spoke with knew how to make a complaint or raise concerns. The complaints procedure for the service was displayed in reception, the waiting area, and in all clinical rooms for patients and those close to them to read. Staff told us they were happy to explain the procedure to patient ensuring they had any contact information required to issue the formal complaint. Advice on how to complain was also available on the provider's website.
- InHealth had a complaints' handling policy and all staff completed a mandatory training course on complaints management. The service operated a complaints' management procedure which aimed to identify and address concerns in a mutually satisfactory manner. Patients and those close to them were encouraged to raise any concerns or issues with staff on duty or the person in charge in the first instance. Staff were empowered to attempt to resolve concerns locally wherever possible.
- Where a patient and those close to them choose to raise a 'formal' complaint, information leaflets explaining the process and available escalation pathways were available in waiting and clinical area. Formal complaints were logged and recorded using the organisation's electronic risk management system. InHealth aimed to acknowledge all complaints within three working days and investigate and formally respond within 20 working days. InHealth operated a three stage complaints management policy: Stage one - local resolution - investigation and response coordinated by local service/ CQC registered manager, Stage two: Internal director review, Stage three: External independent review. External review was provided by either the public health service ombudsman for NHS funded patients or the independent healthcare sector complaints adjudication service (ISCAS) for privately funded patients.
- The service received three complaints and 975 compliments between 8 October 2017 and 31 September 2018. All three complaints were dealt with under the formal complaints procedure. All three were upheld. Complaint themes included: patient pathway (2), staff related (1). All complaints had been investigated and a response had been provided to the complainant. In the team meeting minutes, learning from complaint investigations were recorded.

Are diagnostic imaging services well-led?

Good

We rated this service as **good.**

Leadership

- Leaders had the skills, knowledge, experience and integrity to manage the service.
- The InHealth management structure within the unit consisted an on-site 0.3 full time equivalent (FTE) imaging services manager (ISM) and one FTE superintendent radiographer who was on site daily to assist with clinical issues, work and scan. The ISM also managed two other services, a diagnostic service based in the local area, a few miles away and several mobile services. They were supported by a regional head of imaging services.
- The ISM was an experienced and competent senior radiographer. They were knowledgeable in leading the service. They understood the challenges to quality and sustainability the service faced and had pro-active ongoing action plans in place to address them.
- The ISM was enthusiastic and was keen to improve the quality and service provided. They told us they felt well supported by the corporate InHealth team to take forward initiatives and adjust the service if warranted.
- The manager was visible and approachable and was clearly proud of the team. Staff said they felt confident to discuss any concerns they had with them.

- Staff we spoke with were confident in the local management, they said they found both the ISM and the superintendent to be effective in their roles. They were approachable and supportive. All staff spoke positively about the management of the service.
- The service supported staff to develop within their roles. Staff said the ISM was committed to the continuing development of staff and offered access to both internal and externally part funded training programmes and apprenticeships to support staff in developing skills and competencies relevant to their career with InHealth.

Vision and strategy

- The provider had a clear vision and a set of values, with quality and safety the top priority. InHealth had four clear values: Care, Trust, Passion and Fresh thinking. These values were central to all the examinations and procedures carried out daily. Following the company mission to 'Make Healthcare Better' enables all employees to offer a fresh, innovative approach to the care we deliver.
- Staff were aware and understood what the vision and values were and understood the strategy and their role in achieving it. All staff were introduced to these core values at the cooperate induction and then through their annual appraisal and all personal SMART objectives issued at each appraisal were linked to the company's objectives. An objective is a statement which describes what an individual, team or organisation is hoping to achieve. Objectives are 'SMART' if they are specific, measurable, achievable, realistic and, timely (or time-bound). Staff provided examples how they demonstrated the organisational values, with new ideas or examples of care. For example, the service had introduced a standard operating procedure (SOP) for extravasation following a complaint from a patient. Extravasation is the unintentional leakage of intravenous drugs into the surrounding perivascular tissue or subcutaneous spaces.
- The scanner was ten years old and heading towards being at the end of its working live. The service had service level agreement to ensure the equipment was regularly serviced, however, staff at local level were not aware of a capital replacement plan for the equipment. This issue was not on the local risk register. Post inspection we were provided with evidence of a corporate capital replacement plan.

Culture

- Staff told us they felt supported, respected and valued by the organisation. Staff were proud to work for the organisation. All staff we spoke with were very happy in their role and stated the service was a good place to work. All staff talked about the very supportive staff team.
- The service's culture was centred on the needs and experience of patients. This attitude was reflected in staff we spoke with on inspection.
- Action was taken to address behaviour and performance that was inconsistent with the vision and values, regardless of seniority. Feedback from patients about the service they had received, was acted on. If any aspect of behaviour and performance was falling short of the required standard, the practitioners line manager addressed this and provided necessary support and guidance required to attain the relevant standard.
- Staff said they felt well supported in their roles and would be able to challenge practice or raise concerns regardless of role or seniority if necessary. There were clearly defined management structures, Staff told us they felt able to approach leaders across professional boundaries. For example, radiographers would feel comfortable to raise concerns with the Imaging services manager (ISM).
- The service promoted equality and diversity: it was part of mandatory training, and inclusive, non-discriminatory practices were promoted.
- The provider had a whistle blowing policy and duty of candour policy which supported staff to be open and honest. Staff described the principles of duty of candour to us. Staff told us they attended duty of candour training.
- All independent healthcare organisations with NHS contracts worth £200,000 or more were contractually obliged to take part in the Workforce Race Equality Standard (WRES). Providers must collect, report, monitor and publish their WRES data and act where needed to improve their workforce race equality. The provider had produced a WRES report in September 2017 including data from June 2016 - June 2017. There was clear ownership of the WRES report within the provider management and governance arrangements, this included the WRES action plan reported to and considered by the Board.

- Staff ethnicity was not previously captured in the InHealth in the staff survey and self-reporting of ethnicity was low. There was no comparative data for 2016 because of this. InHealth stated that this would be included within the 2018 report (not yet published).

Governance

- There was an effective governance framework to support the delivery of the strategy and good quality care. The service undertook several quality audits, and information from these assisted in driving improvement and giving all staff ownership of things had gone well and action plans identified how to address things needed to be improved.
- InHealth operated a comprehensive clinical governance framework which aimed to assure the quality of services provided. Quality monitoring was the responsibility of the location registered manager and is supported through the InHealth clinical quality team through the framework and governance committee structure. This included a quarterly risk and governance committee, clinical quality sub-committee, medicines management group, water safety group, radiation protection group, radiology reporting group and a weekly meeting for review of incidents and identification of shared learning.
- Local governance processes were achieved through monthly team meetings and local analysis of performance, discussion of local incidents. Feedback and actions were fed into processes at a corporate level. We saw evidence of this process in meeting minutes and meeting notes during our inspection.
- Staff were trained and supported to ensure they were competent in incident reporting, complaint handling.
- Staff were supported in developing local policies and protocols as well as implementing corporate policies and procedures. However, there were two protocols passed their time for review. The abdomen and pelvis protocol was due for review in July 2018 and the orthopaedic protocol was due for review in August 2018. We raised this with the registered manager at the time of inspection, they were aware of the delay and were working to ensure the reviews were addressed.
- Staff were clear about their roles and understood what they were accountable for. All clinical staff were professionally accountable for the service and care that was delivered within the unit.
- Working arrangements with partners and third-party providers were managed. For example, there was service level agreement between the service and the local acute trust. The service provided a monthly quality reports and held regular meetings with radiology services manager at the acute trust to discuss the service provided.

Managing risks, issues and performance

- There was a risk assessment system in place locally with a process of escalation onto the corporate risk register. The local risk register was reviewed and updated, and some new risks added. The risk register included quality performance, operations, human resources, health and safety, finance, legal, IT systems, procurement and information governance. An action log was also included identifying timescales and accountability. However, we were aware the MRI scanner was about ten years old and heading towards being at the end of its working life. While the service had service level agreement to ensure it was regularly serviced, the staff on site were not aware of the plan to replace the equipment. This was not on the risk register. Post inspection we were provided with evidence of a corporate capital replacement plan.
- Performance was monitored on a local and corporate level. Performance dashboards and reports were produced which enabled comparisons and benchmarking against other services. Information on turnaround times, 'did not attend rates', patient engagement scores, incidents, complaints, mandatory training levels amongst others were charted.

Managing information

- Electronic patient records were kept secure to prevent unauthorised access to data, authorised staff demonstrated they could be easily accessed when required.
- Staff had access to InHealth policies and resource material through the InHealth computer system.
- There were sufficient computers available to enable staff to access the system when they needed to, and the manager had a laptop computer.
- Staff were able to locate and access relevant and key records easily, this enabled them to carry out their day to day roles.
- Information from scans could be reviewed onsite and remotely by authorised referrers to give timely advice and interpretation of results to determine appropriate patient care.

Good

Diagnostic imaging

Engagement

- Attempts were made to gather patients' views and experiences. The service acted on information gained, to shape and improve services and culture. Patient surveys were in use, questions were sufficiently open ended to allow people to express themselves. We saw changes were implemented following feedback from patients. For a complaint about a staff member's attitude, following investigation, the complainant was apologised to and the staff member was supported to set personal objectives to improve patient interactions. Complaints discussions were a standing agenda item at team meeting.
- Staff told us they felt actively engaged, their views were reflected in the planning and delivery of services and in shaping the culture. Following feedback from a staff member regarding improving privacy and dignity, the service changed their pathway for preparing patients for small bowel examinations. It was noted by a member of staff that people drinking bowel preparation prior to their examination were doing so in the main waiting area. Patients preparing for this examination often had difficulty consuming fluids and as such made them feel unwell. Patients were moved to a private area with close access to a toilet when drinking the bowel preparation. They were closely monitored by clinical staff rather than reception staff.
- Annual staff satisfaction surveys were undertaken. These were used to seek views of all employees within the organisation and actions implemented from the feedback received. The Midlands results for January 2018 survey which indicated 85% of staff said, at work, "I have the opportunity to do my best every day", 90% of staff said, "if one of my friends or family needed care or treatment, I would recommend InHealth's services to them", 93% of staff said, "patient safety is a key priority at InHealth" and 89% said, "equality and diversity are valued at InHealth".
- The service had a good relationship with local NHS trust. The service engaged regularly with radiology services manager at the acute trust to discuss the service provided.
- An employee wellbeing and assistance programme was available to staff to support them during times of crisis and ill-health.

Learning, continuous improvement and innovation

- Staff could provide examples of improvements and changes made to processes based on patient feedback, incidents and staff suggestion. Staff were alert to new initiatives and ways of working. For example, the service had introduced a standard operating procedure (SOP) for extravasation following a complaint from a patient. Extravasation is the unintentional leakage of intravenous drugs into the surrounding perivascular tissue or subcutaneous spaces. The SOP provided better guidance for the clinical team to ensure that the patient was cared for appropriately and informed. It also ensured a consistent approach to extravasation. Any extravasation was documented and followed up to ensure the patient did not suffer any pain or further complications after they leave the site. All clinical staff we spoke with were aware of the incident and the improvements that had been put in place.
- The team were proactive in their aim to improve care for patients using the service. The service had recently reviewed the management and support structure of the clinical teams and employed a second superintendent, this was to provide day to day line management and clinical support to the team.
- InHealth were working towards accreditation with the Imaging Services Accreditation Scheme (ISAS). The director of clinical quality was leading on the accreditation.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The service should monitor that all risk items are recorded on the service risk register.
- The service should implement a quality assurance of images audit for radiographers.
- The service should monitor that protocol reviews are timely.
- The service should review infection prevention and control practices for example, about fixing of signage and protective covering for wedges used for patient comfort in the MRI room.