The Pavilion Clinic

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The Pavilion Clinic is a joint venture between BMI Healthcare (52%) and Global Diagnostics Limited (48%). Global Diagnostics Limited is the registered provider and the service is based within the BMI Three Shires Hospital in Northampton.

The senior management of the service is provided by BMI Healthcare staff who work collaboratively with Global Diagnostics Limited. The registered manager is the general manager of the Three Shires Hospital.

Staff working within the service are employed by Global Diagnostics Ltd, with the exception of the imaging manager who is employed by BMI Healthcare.

Facilities include two general x-ray rooms, one with fluoroscopy, ultrasound and an MRI scanner. The service provides diagnostic imaging to inpatient, outpatient and the hospital's operating theatre. Approximately 48% of the patients attending the service are NHS funded, with the remaining 52% being privately funded. Patients are predominately from within Northamptonshire, however, national and international patients frequently visit the department for investigations.

We inspected this service using our comprehensive inspection methodology. We carried out a short notice inspection on 26 February 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. We do not rate effective for diagnostic imaging services.

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

Services we rate

This was the first inspection of this service using this methodology. We rated it as **Outstanding** overall.

Summary

We found the following areas of outstanding practice:

- Services were tailored to meet the needs of the individual patients and delivered in a way to ensure flexibility, choice and continuity of care. People could access the service when they needed it. Waiting times for investigations were minimal and arrangements to treat patients were in line with good practice.
- All referrals were scheduled an appointment on the same day as receipt in the department. This meant that there was no waiting list, with all referrals allocated an appointment slot within 24 hours of receipt of referral.
- All images were reviewed and reported on by a radiologist within one week of the investigation being completed. The majority of images were reported on the same day.
- The service had managers with the right skills and abilities to run a service providing high-quality sustainable care. Local leadership was integral to the drive to improve the delivery of high quality patient centred care. Leaders had a shared purpose, strive to deliver a high-quality service and motivate staff to succeed.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

Summary of findings

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff were satisfied within their roles and felt supported and proud to work for the organisation.
- There was a systematic approach to continually improving the quality of services and safeguarding high standards of care. Compliance was monitored and performance management arrangements proactively reviewed and reflected best practice.
- There were effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- Safe innovation was celebrated. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services. They worked collaboratively with partner organisations effectively.

We found the following areas of good practice:

- Mandatory training was provided to all staff, and managers had processes in place to ensure compliance.
- Staff were aware of safeguarding and understood how to protect patients from abuse and escalate concerns.
- Infection control risks were well managed. Staff kept themselves, equipment and the premises clean. The service had suitable premises and equipment and looked after them well.
- Patient safety was maintained and there were processes in place to monitor risks.
- Staff were appropriately trained and experienced.
- Patient records were kept up to date and accurately reflected treatments that were given.
- Medicines were stored well. Patients received the right medication at the right dose at the right time. This included radiation doses, which were monitored and administered within guidelines.
- The service ensured that there were processes in place to ensure radiation protection.
- The service managed patient safety incidents well. Incidents were investigated and staff shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Care and treatment was based on national guidance and managers checked to make sure staff followed guidance. The quality of images was regularly assessed through audits and case reviews.
- Staff were competent for their roles and were encouraged to develop. Performance was reviewed and supervision was provided.
- Staff across the whole hospital worked collaboratively to provide a seamless service.
- The service flexed its availability to provide a 24-hour service, although the main business hours were Monday to Friday 8am to 8pm.
- Staff cared for patients with compassion and provided emotional support. All feedback from patients was positive and described a caring and friendly service.

Summary of findings

- Patients felt involved with their care and knew what to expect.

However:

- Mandatory training compliance was below the service target of 100% for 17 out of 25 topics.

Following this inspection, we told the provider that it should make some 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	Outstanding ☆	We rated this service as outstanding because it was responsive and well led. Safe, and caring were good. We do not rate effective.

Summary of findings

Contents

Outstanding ☆

The Pavilion Clinic

Services we looked at
Diagnostic imaging

Summary of this inspection

Background to The Pavilion Clinic

The Pavilion Clinic is managed by BMI Healthcare as part of Three Shires Hospital.The service opened in 2010 and is based at the BMI Three Shires Hospital in Northampton, Northamptonshire. The hospital primarily serves the communities of Northampton and the local population. It also accepts patient referrals from outside this area.

The service has had a registered manager in post since October 2010.

Our inspection team

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

Information about The Pavilion Clinic

The location has is registered to provide the following regulated activities:

- Diagnostic and screening procedures

During the inspection, we visited the diagnostic imaging area which included two x-ray rooms, MRI scanning room and an ultrasound room. We also observed the equipment provided in theatres. We spoke with 15 staff including radiographers, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected once in March 2013, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (October 2018 to November 2018)

- In the reporting period 31 October 2018 to 1 November 2018. There were 5579 plain films, 4044 MRI, 102 Fluoroscopy, 2284 Ultrasound and 1298 image intensifier investigations.

Six radiologists worked at the hospital under practising privileges. The service employed six radiographers, one imaging assistant, three administrators and two receptionists.

Track record on safety October 2017 to November 2018

- No deaths
- No never events
- No serious incidents
- No hospital acquired infections
- No IR(ME)R reportable incidents
- Two complaints

Services provided at the hospital under service level agreement:

- Medical Physics
- Quality Assurance- Ultrasound

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Not rated	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding
Overall	Good	N/A	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding

Outstanding ☆

Diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Outstanding ☆
Well-led	Outstanding ☆

Are diagnostic imaging services safe?

Good

This is the first inspection using this methodology. We rated it as **good.**

Mandatory training

- **The service provided mandatory training in key skills to all staff, and managers had processes in place to monitor compliance.**
- Staff received mandatory training in line with their roles and responsibilities. For example, clinical staff completed annual basic life support training annually, whilst non-clinical staff completed it bi-annually.
- We saw that there were 25 mandatory training topics for staff within the imaging department. The target for compliance was 100%. Eight out of the 25 topics were recorded as being completed by 100% of staff, with nine further topics being completed by over 90% of staff. Compliance for the remaining topics varied between 33.3% (adult immediate life support and 89.5% (fire safety in a hospital environment). It was noted, that some topics were relevant to small numbers of staff and therefore none compliance by one member of staff made a significant impact on compliance score. For example, documentation and legal aspects was applicable to four members of staff, with three completed and one in progress, giving a compliance score of 75%.
- The majority of mandatory training was completed online, with a small portion of topics completed face to face (fire safety, manual handling, hand hygiene and basic life support).
- Staff could access training up to six months before expiry which meant that compliance was maintained. All mandatory training was completed on induction and then repeated at set intervals according to the topic.
- The imaging manager had access to all staffs' training records and printed monthly tables highlighting compliance. The heads of department used this to highlight training needs and encouraged staff to complete training in a timely manner.
- All bank staff were expected to complete the local mandatory training topics and compliance was checked annually as part of a performance review.
- Staff reported that they were given time to complete mandatory training.

Safeguarding

- **Staff understood how to protect patients from abuse and knew how to escalate concerns.**
- The service routinely completed investigations for patients under 18 years and had therefore completed training to ensure the safety of children attending the department. Service data showed that all staff had completed safeguarding children training level 2 and all radiographers had completed safeguarding children training level 3. All staff were able to describe how they would escalate any concerns regarding a child's safety.

Diagnostic imaging

- Similarly, all staff completed safeguarding adults training level 1, with radiographers completing safeguarding adults level 2 training.
- Staff were able to tell us who was the safeguarding lead and describe situations that would be referred.
- Staff told us that they had completed female genital mutilation (FGM) training to raise awareness. Staff spoke openly about this topic explaining that they were located in an area of high prevalence due to the diversity of the population. FGM training was completed by administration staff as well as clinical staff.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.**
- All areas inspected were visibly clean and clear of clutter. We saw staff cleaning equipment between uses and items not in use were labelled that they had been cleaned.
- Staff were observed washing their hands and using hand sanitisers, and personal protective equipment was available and used as necessary. Staff were bare below the elbow when completing tasks within the clinical area.
- Staff who attended theatres were observed to adhere to the infection control and prevention guidelines to ensure they did not contaminate the environment.
- Infection control training was mandatory for all staff. Records showed that all staff were 100% compliant.
- There were cleaning schedules displayed and staff used checklists to ensure that tasks were completed in line with recommendations. We saw that these were updated and signed when tasks were completed.
- We were told that infection control was monitored by the heads of department, imaging manager and the hospital infection control lead monthly. This was completed through ad-hoc walkabouts and an audit programme. The majority of audits showed 100% compliance with infection control and prevention (IPC) audits. There was one occasion when the service scored 97% in a hand hygiene audit, as a result of a staff member wearing a ring. We were told that this was addressed immediately.
- A service representative was expected to attend the hospital infection control and prevention meetings. Minutes from these meetings confirmed attendance. We also saw that information gathered at these meetings was cascaded to staff locally.
- Waste was managed appropriately, with items segregated according to their type, for example, domestic and clinical waste. We also saw that sharps boxes were assembled correctly and closed when not in use.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
- The service was located on the ground floor of the Three Shires Hospital, adjacent to theatres and the outpatients' department. The department was easily located and signposted.
- The department consisted of a waiting room with a manned reception desk. X-ray room one, was connected to the reception area, had an adjoining changing room, with direct access into the x-ray room and the reception area. A doorway led to a corridor which enabled access to theatres, the ultrasound room, magnetic resonance imaging (MRI) room, x-ray room two and a series of offices, stores and changing rooms. Although access to the corridor was not secure, the reception was manned when the department was open, and therefore patients or unauthorised persons could not access the clinical areas. Patients were accompanied from reception, to ensure that they attended the correct clinical area.
- Access to the MRI scanner was secure with code access and a call bell for visitors. This ensured patients and staff safety and reduced any risks associated with foreign objects that may cause damage to the scanner.
- During inspection, x-ray room two was being refurbished, and we were therefore unable to inspect this area. The refurbishment had been arranged to enable access to the room from outside the

department. This meant that there were no contractors within the department and there was no debris normally associated with building works, therefore the service could continue to function as normal without disruption.

- Service data and staff told us that equipment was well maintained. Equipment was managed under a service level agreement with the manufacturers. During inspection, we saw an external contractor for the MRI scanner completing a service. This had been planned and the patient schedule arranged to enable sufficient time for works to be completed. The contractor kept staff informed of progress with the works.
- Staff told us that there was a preventative maintenance and replacement schedule for all equipment. There was also a fault book used to record any items which required maintenance. We saw that there were 12 faults recorded since June 2017, which included problems such as damaged cables and connectors. These faults were noted to be common to this type of service.

Assessing and responding to patient risk

- **The service had systems in place to ensure patient safety.**
- There were a number of safety measures employed by staff to ensure that patient safety was maintained. We saw that there were processes in place to check that the right person was receiving the right investigation. This included the referral form being checked against the requested investigation and verbal confirmation by the patient as to their demographics and expected investigation.
- Patients were referred to the service through a number of sources, including GPs and consultants. On receipt of the referral the investigation proposed was screened for appropriateness, to ensure the right investigation was being requested according to the patient's complaint. If there were any concerns, the request was discussed with the referrer for clarification.
- The screening process also enabled staff to identify any pre-existing conditions that may impact on the ability to perform the investigation. For example, patients with impaired kidney function received a different dose of contrast media.
- Patients who received a contrast media for imaging, were reviewed for any allergies prior to administration. Although the service worked to patient group directives (PGDs) which meant radiographers could administer medicines without a prescription. We were told that the radiologist was always present when contrast media was being used. The resident medical officer (RMO) was also available to support staff in the event of an adverse reaction to medicines. We saw one incident reported which detailed an adverse reaction and the actions taken by the team, including the RMO were clearly described.
- Staff had access to a paediatric and adult resuscitation trolley in the event of an emergency. We saw that these were stocked appropriately and checked daily. Single use equipment was clearly labelled and items remained in sealed packaging.
- The Society of Radiographers (SoR) "pause and check" system was used with posters displayed. Pause and check refers to the SoR operator checklist which prompts radiographers to confirm the correct patient and the investigation prior to completing the investigation. We saw this in use throughout the inspection.
- Within reception, there was a poster identifying that anyone who suspected that they may be pregnant should inform the clinician prior to the investigation being completed.
- The "local rules" were displayed across clinical areas. These identified the risks associated with each modality and steps taken by staff to ensure that procedures were completed safely.
- Patients attending for an MRI scan were required to complete a questionnaire prior to the investigation. The questionnaire adhered to guidance from the British Association of Magnetic Resonance Radiographers (BAMRR). On arrival patients were given the questionnaire by the reception staff. When called, the radiographer reviewed the questionnaire with the patient to ensure that there were no factors which

could affect the patient's safety, for example, an internal pacemaker, containing metal. If a patient identified any risks, the investigation was not completed and the patient referred back to the consultant for an alternative investigation to be identified.

- We saw the World Health Organisation (WHO) steps to safer surgery process was used in theatres and interventional imaging. The checklist was completed to confirm compliance with safety checks as an observational audit tool. This meant that there were additional steps in place to ensure patient safety for invasive procedures. Regular audits were completed to ensure compliance with the WHO checklist.
- There was clear signage for each clinical room to identify that staff and patients should not enter. X-ray rooms had appropriate lights identifying when radiation was being exposed. We were told that warning lights and emergency call bells were tested a minimum of weekly. Staff told us the other departments in the hospital were notified of the checks to prevent actions being taken.
- The lead paediatric nurse (LPN) was made aware of the times of all children's' appointments. This was completed through the electronic database which automatically alerted the LPN of any appointments made for people who were under 18 years.
- All staff wore radiation badges to monitor any occupational doses. These were monitored bi-monthly to review staffs' exposure to radiation. The assessment and record keeping of radiation doses are recommended under Regulation 35 Ionising Radiations Regulations 1999.
- Locally the team had introduced a safety huddle which identified any issues for the day's activities and any information from the wider hospital. For example, we saw that the safety huddle identified the servicing of the MRI and the fact that the fire alarm was disabled in x-ray two due to the building works. We were told that the information was displayed daily for all staff to see, then scanned into the electronic database for archiving.
- As part of the wider hospital team, a representative from the department attended the hospital safety briefing. This enabled any at risk patients to be identified and shared with the wider team. The safety huddles occurred daily, and were attended by the leads from each department and the senior management team. We saw that information was shared across all teams at these meetings.
- In addition to the safety huddles, the imaging manager also attended the daily bed management meeting. This enabled planning for activity, such as post-operative needs at weekends.
- Medicines and Healthcare products Regulatory Agency alerts (MHRA) and company safety alerts were sent directly to the imaging manager for actioning. Any alert was checked against the department to ensure actions were taken to address the alert. All alerts were discussed with staff and recorded on the safety huddle forms, or team meeting minutes.

Staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.**
- The service had six permanent imaging staff which included one whole time equivalent (WTE) clinical service manager, three (WTE) senior radiographers and two (WTE) radiographers. They were supported by one (WTE) diagnostic imaging assistant, and five (WTE) administrative staff.
- The staff turnover for the service was reported to be small. Five members of the team had left the service over the year October 2017 to November 2018. These had been due to retirement or carer progression. We were told that recruitment had been challenging, however, the service had been successful in recruiting a number of experienced staff, as well as developing staff internally.
- There were a small number of bank and agency staff used to support activity. Service data showed that within a three-month period (August to October 2018) there were 63 shifts supported by radiography bank and 77 shifts supported by agency radiography staff. For the same period, there were 96 shifts supported by bank administration staff. The same bank and agency staff were used to cover these shifts to ensure

consistency. We were told that one consultant radiologist requested a specific radiographer for their list, ensuring consistency and competency for the investigations being completed.

- Sickness figures for the service show that radiography sickness was at 5.9% and administration staff 5.49%. There was not a target for sickness. We saw that sickness was monitored and staff were expected to complete a return to work interview with their line manager on their return from sick leave.
- There were two radiation protection supervisors working within the department with clear roles and responsibilities. This was in line with guidance and assisted to identify and manage patient risks.

Medical staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.**
- The service had a radiologist rota which matched the schedule/ activity. This process enabled images to be reviewed by the most appropriate clinician with the appropriate competency. For example, during inspection, we saw that there was a radiologist present to complete an ultrasound list. Reporting was completed for these investigation as they were completed.
- Six consultant radiologists worked under practising privileges following a rigorous vetting process. All consultants carried out procedures that they would normally carry out within their scope of practice. Consultant radiologists, who were new to the hospital received a formal induction.
- Radiologists were required to produce evidence annually of their professional registration, revalidation, indemnity insurance, appraisal, mandatory training and continuous professional development before their practicing privileges were renewed.
- All inpatients were under the care of a designated consultant and the referring consultants were accessible in and out of hours. In addition, the service was able to access the resident medical officer (RMO) for the main hospital if needed. The RMO was available 24 hours per day, seven days per week.
- Emergency referrals were accepted by a consultant to consultant referral only. This meant that in the case of an emergency or urgent referral the consultant was contacted and the procedure arranged.
- Consultants participated in the medical advisory committee (MAC) meetings for the main hospital. A radiologist represented the service and acted as a link between the hospital and the service.

Records

- **Staff kept appropriate records of patients' care and treatment. Records were clear, up to date and available to all staff providing care.**
- The service used two electronic systems for managing and processing investigations. The systems ran parallel to each other and duplicated information, however, one was specific to Global Diagnostics Limited and the other specific to the Three Shires Hospital. Administration staff showed us the process for planning, recording and billing investigations using the system, and whilst there was some duplication, the process was efficient. Staff told us that they were working on a merge of systems to prevent duplication, however, this was still in development. The aim was to complete the merge project on site and then roll out across the organisation.
- We saw that images were clear and of good quality. Images were recorded on the picture archive and communication system (PACS). PACS could be accessed by all staff to enable checking of images and reporting. Staff checked the patients details and PACS prior to completing the investigation to ensure that the image/investigation had not already been undertaken.
- The service was able to transfer images to external sites using an image exchange portal. This meant that images taken could be reviewed by radiologists remotely or the referring consultant at a different site.

Diagnostic imaging

- We saw that the WHO checklist, consent form and clinical coding forms were scanned onto the database following any procedure. This meant that information was recorded in a timely manner and accessible within the patient record.
- For those patients who were not an inpatient, image reports were sent directly to the referring consultant or GP once they had been reviewed. All images were reported on by a radiologist, this included those images taken during procedures in theatres. This meant that if there were any suspicious or abnormal findings on an image, not relating to the clinical condition, it would be flagged to the referring consultant. For example, if a chest x-ray was taken to identify a shoulder injury and an abnormality within the lung field was identified this would be escalated to the consultant.
- Throughout the department, care was taken to ensure that computer screens were not accessible or in view of unauthorised persons. Computers were locked when not in use. There was a IT helpline for any issues and the IT manager for Global Diagnostics Limited attended the site weekly. There was a clear process for staff to follow in the event of IT failure.

Medicines

- **The service prescribed, gave, recorded and stored medicines in line with best practice. Patients received the right medication at the right dose at the right time.**
- There were minimal medicines administered within the department, with the majority used for image enhancement (contrast media). We saw that care was taken to ensure that the right patient received the right medicine. Patients identity was checked, confirmed and then checked against the prescriptions.
- We saw that all medicines were stored in locked cupboards in a restricted access room. The stock was managed by the pharmacy team, and we found that cupboards were organised and stock rotated. Medicines we checked were within expiry dates.
- The on-site pharmacy team supported staff with any queries regarding medicines and provided training as necessary. Pharmacy was available five days per week, with out of hours assistance through the on-call manager if needed at weekends.
- The service used a number of patient group directives (PGDs) to enable appropriately trained radiographers to administer medicines without a prescription. These were in line with guidance and were specific to investigations. We saw that the PGDs had been reviewed and were in date.
- Medicines used for interventional radiography were prescribed and administered by the consultant radiologist. We saw that contrast media was signed and dated by the radiologists and countersigned by the radiographer. This met the Royal College of Radiologists standards for intravascular contrast administration to adult patients.

Radiation Dose

- **Radiation doses were monitored and administered within guidelines.**
- Dose reference levels were set by an external radiation protection service in line with the national reference levels. Staff reported that there was an effective relationship with the external provider and told us that they were responsive to their needs.
- Radiation dose audits were completed at regular intervals to ensure that equipment was working effectively and ensure patients and staff were not at risk.
- We saw that investigations were completed within the dose reference levels and audits were completed regularly to ensure compliance and safety.

Radiation Protection

- **The service ensured that there were processes in place to ensure radiation protection.**
- The service had a full set of the IR(ME)R procedures and operating procedures as required under regulations. There were two radiation protection supervisors (RPS). RPS are required for the purpose of securing compliance with IRR17 and local rules.

Diagnostic imaging

- Radiation protection services were supplied by an external company. The company were responsible for the provision of a radiation protection advisor (RPA) and magnetic responsible person as required by UK law. There was a RPA audit process in place. We saw that the radiation protection agreement outlined clearly the roles and responsibilities of individuals and the service.
- The radiation protection audit was completed in September 2018. The report stated that there was "good compliance with regulatory requirements. A number of minor recommendations for improvements were made during the visit, mostly due to the update to the regulations". These included, the updating of the policy to reflect the new regulations, the updating of the risk assessment using the new BMI template and a radiation protection committee meeting for January 2019. We saw that these actions had been completed during our inspection.
- A radiation protection committee meeting was held every six months. This was a formal meeting, and we saw that it was well attended and chaired by the quality and risk manager. The meeting reviewed aspects appropriate to radiation protection, such as audit results, policies, equipment changes and training. There was a clear action plan with nominated leads for completion. The January 2019 meeting detailed actions such as training theatre staff in radiation protection, equipment competencies and the random monitoring of results.

Incidents

- **The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.**
- Incidents were reported using an electronic database. Service data suggested that staff were actively encouraged to report any incidents or near misses.
- There was clear guidance on the levels of investigation required for incidents depending on their severity. Local policy described actions to be taken in the event of an incident and the level of reporting required. The service reported no never events and no serious incidents.
- Staff were aware of their roles and responsibilities in managing complaints and spoke about being open when things went wrong. We were told that duty of candour would be applied to incidents that caused moderate and severe harm or death. There were no incidents that triggered formal duty of candour to be applied from November 2017 to November 2018.
- During inspection, we observed a telephone call to a patient to discuss a repeat investigation. Whilst this did not relate to an incident, it was clear from the conversations between staff and with the patient, that the staff were being open about the reasons for requesting a second investigation.
- From February 2018 to February 2019, there were 40 incidents reported within the imaging department. These included 32 incidents that were categorised as no harm or not applicable, and eight incidents that were categorised as low harm. There were no reportable incidents associated with either patient harm or in line with Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R).
- We saw that the senior management team had agreed to investigate two incidents that had occurred within the imaging department as if they had triggered an external investigation (root cause analysis- RCAs) even though they did not meet the criteria. We saw that the incidents resulted in no patient harm. The RCAs were completed following a discussion regarding the incident and the potential for learning. Investigations were clear, detailed contributing factors and outcomes, such as reflective accounts by staff involved.
- Staff told us that patients and relatives were included in any investigations into incidents, and kept informed of progress and identified learning.
- We were told that any incidents that occurred were discussed as part of the team meetings and as part of the wider hospital team to promote shared learning. We saw from team meeting minutes and safety huddle checklists that incidents were discussed at safety huddles, and in team meetings.

Diagnostic imaging

- We saw that incidents were discussed as part of the governance meetings and the medical advisory committee meetings. This ensured that all specialities were aware of incidents and their learning. Actions relating to specific incidents were tracked and evidence produced to confirm that they had been taken, prior to being closed.
- Staff told us that corporate leads were available to support investigations and for advice. For example, we saw that the IR(ME)R corporate lead had been contacted regarding a radiation dose incident to discuss the level of reporting and intimal actions taken. This incident was not a IR(ME)R reportable incident.

Are diagnostic imaging services effective?

Not sufficient evidence to rate

This is the first inspection using this methodology. We do not rate effective. We found that:

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.**
- Staff worked to the
- The service followed the policies and guidance from the BMI group. We saw that these were based on national guidance and were reviewed regularly. Policies and protocols were easily accessible and staff could locate information and guidance on the hospital intranet. All policies checked were in date.
- There was a file with master copies of standard operating procedures (SOPs). These included SOPs for the communication of critical, urgent or unexpected significant findings from radiological exams. All SOPs were clear, easy to understand and reviewed regularly to ensure that they were up to date.
- We saw that there was a process in place to notify staff of changes in policy and guidance, with a tick sheet for staff to sign to confirm that they had read and understood any changes.

Nutrition and hydration

- Patients attending the department were not routinely provided with food or drink, however water was available in the waiting room.
- Patients attending for invasive procedures were advised on whether they could eat or drink in advance of their appointments. Appointment letters gave instructions and staff confirmed directions prior to appointments.

Pain relief

- Pain relief was not routinely used, with the exception of when patients were attending for an invasive procedure and local anaesthetic would be used. Staff provide pain control specific to the investigation being undertaken. Patients were asked to confirm that local analgesia was effective throughout invasive procedures.
- Staff ensured patients comfort prior to completing simple diagnostics, such as ultrasound and x-rays. We saw that patients were assisted to reposition themselves if they reported discomfort, and reassurance of the time required in that position.

Patient outcomes

- **The service did not directly monitor patient outcomes. However, were involved with patient pathways, monitoring and national audits.**
- The service provided images for cases which were part of national audits such as the National Joint Registry and Patient Recorded Outcome Measures. Patients treated at the hospital were usually on specific pathways and required images to be completed. The service therefore ensured that images were completed in line with pathways which enabled audits to be completed.
- **The service monitored the quality of images through regular audits and case reviews in**

multidisciplinary team meetings and training sessions. Staff told us that they regularly discussed images at team meetings or training sessions which enabled discussions on techniques and best practice.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staffs' work performance and held regular supervision meetings with them.**
- There was a robust process for inducting staff to the department and all staff completed competencies specific to the areas worked. For example, staff working within magnetic resonance imaging (MRI) had specific competencies for working within that area. Training and competency folders were maintained and updated annually.
- The service saw under 18-year-old patients regularly. All staff were trained in paediatric basic life support and radiographers had paediatric awareness competencies which were signed off by the paediatric lead nurse.
- All staff administering radiation were appropriately trained to do so. Those staff who were not formally trained in radiation administration were adequately supervised in accordance with legislations set out under IR(ME)R). There were lead radiographers for each modality, who worked with the imaging manager to ensure the delivery of recommended standards as recognised by the Society of Radiographers (SoR).
- All radiographers were registered with the Health Care Professional Council(HCPC). The clinical service manager checked registration frequently to ensure staff had reregistered annually.
- All staff were required to complete a Disclosure and Barring Service check prior to commencement in post. We were provided with a list of all substantive and temporary (bank) staff which detailed the level of checks and the compliance with the enhanced checks.
- Bank staff were inducted to the service through the hospital induction day and had a designated training folder, which was reviewed annually as part of their performance review. All bank staff completed induction in line with the BMiLearn programme, completing clinical and equipment competencies.
- All agency staff completed an agency induction sheet on commencement of their first duty. This induction sheet ensured that staff had knowledge of any relevant specific needs for the department including emergency equipment location, fire exits and how to escalate any concerns.
- Staff told us that when equipment was changed, they received training from the manufacturer prior to using the items. We saw that new to post staff were also supported to become familiar with equipment even if they had previously used the same or similar products in previous jobs.
- The service offered monthly clinical supervision sessions that were open to clinical and non- clinical staff when appropriate.
- The hospital ran scenarios which included staff from the service. The scenarios were usually based on an emergency or activity which required staff to work collaboratively to manage. Some scenarios were based on real events and this enabled staff to learn and share what could have been done differently.
- Service data showed that 100% of staff had completed an appraisal within the last 12 months. Appraisals were noted to be effective and centred on the individuals learning objectives. We were given examples of additional training for staff to explore specific interests.

Multidisciplinary working

- **Staff of different disciplines worked together as a team to benefit patients. Doctors, radiographers and other healthcare professionals supported each other to provide good care.**
- Throughout the inspection we saw that the team worked collaboratively. We saw administrative staff and radiographers planning patients' treatments and open discussions with radiologists regarding workload.
- The administration staff worked collaboratively with the clinical staff to ensure that all patient bookings

were completed appropriately. The team managed the reception area, facilitation of the image exchange portal, patient bookings and billing. Any queries were discussed.

- We observed radiographers working within theatre, and saw that they engaged with the theatre staff and consultants to achieve the outcomes for the patients being operated on. The consultant surgeon reported that there was a positive relationship between imaging staff and staff cross the hospital.
- Bank and agency staff were reported as being included in any training being delivered on the day worked. For example, a bank staff member could be included in a case study, peer review or multidisciplinary team (MDT) meeting if held on the day worked.
- We were told that the radiologists had been asked to provide a bimonthly training session on topics of their choice. This worked in conjunction to training provided by the radiographers.
- Staff told us that they completed case reviews as part of their training. These included a number of clinicians discussing patients' treatments to identify any learning.
- MDT meetings were completed every quarter to review complex cases. These were led by the radiologist lead.

Seven-day services

- **The service predominantly provided a five-day service, with flexibility to cover weekends when needed. There was on call cover out of hours.**
- The usual business hours were Monday to Friday 8am to 8pm, although we were told that the service was open during any outpatient appointments to facilitate investigations to coincide with appointments. This meant that hours of the service flexed according to the wider service need.
- At weekends the service provided cover at the request of a consultant, for specific clinics. Again, this was to ensure that investigations could be completed preventing patients returning to the hospital.
- Out of hours there was a designated radiographer and radiologist who would manage any urgent or emergency referrals. The on-call system consisted of a radiographer and radiologist for reporting. Staff reported that they seldom needed to attend out of hours.

Consent and Mental Capacity Act

- **Staff understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients who lacked the capacity to make decisions about their care.**
- Staff told us that they had received mental capacity training and knew how to escalate any concerns, although had not had the need to do so. Any concerns were directed to the head of department or imaging manager.
- Patients were required to make an informed decision prior to attending for their appointments. To enable patients to do this, the service provided information about the planned investigation at the point of booking the appointment. Upon arrival to the department, the patient was given time to ask any questions prior to the investigation being completed. Consent was obtained for all investigations either verbally for non-invasive procedures or written for interventional imaging. Staff reported that this worked well and patients had sufficient time and information to make decisions about the investigations planned.
- Patients who were under 18 years were able to consent to procedures using the Gillick competency. Staff reported that the majority of their patients who were under 18 years were athletes who were associated with the local sports organisations. Staff reported that consent was always obtained before procedures and time was given to explain any investigations planned.

Are diagnostic imaging services caring?

Good

This is the first inspection using this methodology. We rated it as **good.**

Compassionate care

Outstanding ☆

Diagnostic imaging

- **Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.**
- Throughout the inspection, we saw that patients were treated with care and respect. Staff were friendly and engaged in conversations with patients to help them relax.
- Patient feedback confirmed that they were treated with dignity. Doors were locked when patients were receiving treatments or scans and changing rooms were directly accessible to investigation rooms to prevent patients being seen in gowns, by other waiting patients.
- Staff introduced themselves to the patient when calling them for their investigations. Staff took into consideration any disabilities, assisting patients to mobilise or reposition as necessary.
- The service captured patient feedback following their experiences within the department. On inspection, we saw three completed comment cards which were all positive and all recommended the service. Comments such as "everyone was friendly and helpful from end to end" and "fast and efficient, very pleasant staff".
- In addition to comment cards, the service collected information from social media. We were given a selection of feedback which included comments such as, "thank you for sorting this out" and "Thank you so much for a fantastic service".
- We saw that staff offered to comfort patients during procedures. For example, one radiographer offered to hold the patients hand during a procedure.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- We saw that staff showed awareness of the emotional and social impact that a person's care, treatment and condition would have on their well-being. Patients were given the opportunity to speak at length about any concerns and conversations were held in private. When completing intimate investigations, patients were reassured and spoken to in a sensitive manner.
- Staff were observed talking through procedures and ensuring that the patient was comfortable and happy before completing investigations.
- Patients could access and be given appropriate and timely support and information to cope emotionally and mentally with their treatment or care. We were told that patients who were known to have any mental health, dementia or learning disability diagnosis were offered longer appointments to enable patients time to ask any questions and familiarise themselves with staff and equipment.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment. Patients felt involved with their care and knew what to expect.**
- Throughout the inspection, we saw that staff engaged with patients and their relatives if in attendance. Staff ensured that patients knew what was going to happen, and explained the process and next steps.
- Patients told us that they were included in decisions about treatment.
- Staff were observed explaining information in an unhurried manner. Some patients reported that staff responded well to questions and gave useful information. Some written feedback included, "Everything explained well, made to feel comfortable."

Are diagnostic imaging services responsive?

Outstanding ☆

This is the first inspection using this methodology. We rated it as **outstanding.**

Service delivery to meet the needs of local people

- **The service was tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care.**
- Radiographers worked shift patterns to ensure that the service was available from 8am to 8pm. There was

flexibility with the opening hours as the service ensured that there was a radiographer available for all outpatient clinics. This ensured that investigations were available at the time of patient's treatments and prevented repeated visits.

- The service was located on the ground floor next to the main hospital reception. Patients walked past the imaging unit on the way to the outpatient's unit, and therefore there was no confusion as to its location. There was clear signposting.
- The environment was appropriate to needs, with sufficient seating, water cooler, a selection of magazines and access to toilets. There was a small selection of children's toys available, although staff told us that patients usually brought their own entertainment and were usually in the department for short periods of time.
- The service was flexible, provided informed choice and ensured continuity of care. The majority of appointments were made by telephone and booking staff ensured that appointments suited the patients' needs and preferences.
- All appointments, if made with sufficient time in advance, were confirmed in writing. At the time of booking, the booking team completed a letter detailing any requirements for the investigation, such as fasting, and any information relating to the department location and car parking. If the appointment was arranged for an appointment slot within 48 hours of the booking call, key information was shared during the booking telephone call. This ensured that the patient knew what they needed to do for their appointment.
- When planning appointments, the booking team identified if individuals required additional time or facilities. For example, for patients living with dementia, additional time was allocated to the appointment to enable staff to spend time explaining procedures.
- Car parking was allocated to visitors and enabled easy access. Patients who required walking aids or wheelchair access were able to park nearer to the hospital main entrance and staff told us they would assist patients if necessary. There was an MRI safe wheelchair available for patients who were unable to mobilise independently to the MRI suite.
- Appointments ran to time, and during inspection, we saw that patients waited for less than ten minutes for their investigation. On being called for the investigation, staff always apologised for the wait.
- The service worked closely with the local mental health hospital to provide any investigations for their patients. Staff were able to allocate additional time and demonstrated an awareness of mental health needs.
- Non-emergency interventional radiology services were provided by the radiologists and consultants as part of a schedule of work. We did not see these during our inspection.
- Paediatric radiology provision was provided, although complex and interventional services were completed at the local NHS acute hospital or referred to specialist centres.

Meeting people's individual needs

- **The service was tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care.**
- There was a proactive approach to understanding the needs and preferences of patients using the service, promoting equality. Any additional needs were identified at the point of appointment booking. Each patient was spoken with to identify when they would like to attend for their appointment. Staff told us that referrals generally indicated any conditions that may impact on the patient's ability to attend the appointment, or those with additional needs. For example, patients with a learning disability.
- We were told that patients with additional needs were often called through for their appointments immediately. Reception staff notified each modality of the patient's arrival and staff called patients into the treatment rooms as soon as possible.
- Patients were able to attend with their families, and we saw that staff informed relatives of duration of investigation and in some cases allowed relatives to

accompany patients into the investigation rooms. Similarly, those patients with additional needs, such as those with a mental health diagnosis, learning disability or those living with dementia, were able to be accompanied.

- Children using the service were provided with additional time and support from the team. Longer appointments were scheduled and staff took time to ensure children understood the investigation being completed. There were a number of toys and games which could be used to distract children from procedures.
- The service had a wide bore magnetic resonance imaging (MRI) scanner which meant that it was more comfortable for larger patients and less claustrophobic.
- The service had a proactive approach to understanding the needs of different groups of people to deliver treatment in a way that met individuals needs and promoted equality. For example, there was a translation service available for people whose first language was not English, although staff reported that this was a small proportion of patients. Staff told us that patients using the translations services, were always asked to confirm if they were happy for information to be shared with their relatives, ensuring privacy.
- A hearing loop was available at reception, and staff told us that interpreters and British sign language (BSL) interpreters could be arranged for any appointment in advance.
- Patient information leaflets were usually sent out to patients at the time of appointment booking, however we saw that a selection of information leaflets was available at reception for those who attended on the day. All leaflets were in English, however, could be translated if necessary. Information leaflets were also available for children, that contained colourful images and simple text.
- Staff provided a communication book for patients with limited communication, which would remain with the patient for the duration of their appointment. Staff told us that they also allocated one member of staff to accompany the patient throughout their appointment to ensure that they could meet any needs and communicate any commands for the investigation.
- The service provided chaperoning and we saw posters reminding patients to ask staff for a chaperone if they wished to be accompanied into their appointments.
- Following appointments, patients were reminded to book any follow up appointments prior to leaving the department. This ensured that patients knew when they were expected to return to the hospital.
- There were policies to ensure that patients were not discriminated against. Staff were aware of service policies and gave examples of how they followed guidance when completing care and treatment. Staff told us that they would escalate any concerns, and seek further guidance if necessary.

Access and flow

- **People could access the service when they needed it. Waiting times from referral were minimal and arrangements to treat patients were in line with good practice.**
- Referrals were largely received from consultants and GPs. There was a paper referral system, and staff used a secure fax machine to receive referrals from outside the hospital. All referrals were vetted by a radiographer prior to booking the appointment, to ensure that the correct procedure had been requested and that the referral contained sufficient information. Magnetic resonance imaging (MRI) was vetted by a consultant radiologist.
- **Peoples individual needs and preferences were central to the planning and delivery of services.**
- We saw that referrals were managed in such a way, that patients were able to pick appointments to suit their needs. Once a referral was received, the booking team contacted the patient to arrange a suitable time for the investigation. Available slots were discussed and the patient could choose what suited according to their commitments elsewhere. All appointments referred were scheduled on the same day as receipt in the department. This meant that there was no waiting

list, with all referrals allocated an appointment slot within 24 hours of receipt of referral. This process was used for all patients, regardless of whether they were private patients or NHS.

- Inpatient referrals were managed the same way as outpatient referrals, with the booking clerk allocating an appointment slot as soon as possible, to prevent any delays in treatment.
- We asked to see the referral list and saw that there were eight referrals not allocated, however, these all referred to referrals which were made in advance of the investigation need. For example, we saw one referral was 78 days old, however, related to a referral made for an appointment in three months' time from the original outpatient appointment. These referrals were dormant until nearer the proposed investigation date, when they automatically changed to active for allocation. This meant that people who were expected to be seen in the outpatients' clinics could arrange appointments to suit them, and not prearrange appointments which may not be suitable nearer the time.
- Appointments were scheduled to coincide with outpatient appointments. For example, patients attending hospital to see the orthopaedic consultant following surgery, had their investigation before their appointment to enable the consultant to review the image during the appointment. This enabled consultants to make informed decisions about care and treatment, and prevented repeated hospital visits.
- Staff told us they provided a service to the local professional sporting teams, and consequently any visiting teams. Referrals were also received nationally from sporting bodies or individuals as the service completed work for consultants with specialist interests. These appointments were scheduled in the same way as the outpatient and hospital appointments. Radiographers and radiologists also provided cover for local sporting events.
- All images were reviewed and reported on by a radiologist within one week of the investigation being completed. The majority of images were reported on the same day, however, if the image required specialist review, there would be a short delay whilst waiting for that speciality radiologist. Staff told us that images could be forwarded to speciality radiologists if an urgent review was required.
- Patients were provided with a copy of their investigation as requested. The service provided images on encrypted compact discs, which enabled patients to have investigations at the hospital and then seek consultant advice elsewhere. Following changes to the general data protection regulation (GDPR) guidelines, the service changed processes to enable images to be shared electronically using an image exchange portal. This service was previously only available to registered locations. The was being trialled at the Pavilion Clinic, with an aim to spread the process across the organisation.
- Patients were provided with details of cost at the point of booking an appointment. Cost and payment of the service was planned in advance of the appointments, which meant that patients did not have to worry about the finances during the investigation.
- The waiting time was displayed at the reception desk, and staff told us that this was updated when changes occurred. Throughout our inspection, the time reported for a wait, was ten minutes.
- Service data showed that there were 16 cancellations from November 2018 to March 2019. The majority (13), related to failed questionnaires for magnetic resonance imaging (MRI) scanning. These patients were referred back to the referring consultant and an alternative investigation was arranged. There were no reported cancellations as a result of machine failure.
- Service data showed that there was one transfer to an acute NHS trust from October 2017 to February 2019. This related to a patient who deteriorated following a reaction to an injection. Again, this incident was investigated to identify any learning.
- Staff told us that they have very few patients that do not attend (DNA) their appointments. Service data showed that for the six months preceding the inspection, the DNA rate was 0.3%. We were told that if a patient did not attend their planned appointment, they would contact the patient directly to ensure that they had not forgotten. Appointments were rescheduled as necessary.

Outstanding ☆

Diagnostic imaging

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. Staff were proactive in ensuring patients concerns were addressed at the time of appointment preventing the escalation of concerns to a complaint.**
- Staff were aware of their roles and responsibilities in managing complaints and could describe the process and escalation. Where possible, staff told us that they would try to resolve any issues as they occurred, ensuring patient satisfaction and resolution.
- During inspection, we saw that staff were open with patients. For example, we witnessed a conversation between a staff member and a patient who was required to re-attend for an investigation. The staff member explained the reasons for the repeated investigation and apologised for the inconvenience. Efforts were taken to ensure that the patient was happy with the new appointment.
- The service captured feedback from patients through comment cards, and we saw staff asking patients for feedback after each investigation. We saw that feedback from patients was discussed as part of safety huddles and highlighted in service reports. This included positive comments and compliments.
- There were patient information leaflets relating to how to complain available at reception. Staff reported that these would be given to any patient who informed them that they were not happy with the service received.
- Local data showed that there had been two complaints relating to the service between December 2017 and August 2018. One referred to the imaging results not being available in time for an appointment and the second referred to the cost of a MRI. Both complaints were recorded as being substantiated and apologies sent to the complainant.
- Complaints were investigated by the most appropriate person. For example, a complaint about staff attitude would be investigated by the local manager, and complaints about treatments would be investigated by a consultant or clinician. All complaint responses were reviewed by the senior management team prior to being sent.
- There were no complaints referring to the service that met the duty of candour criteria. Staff were able to describe when they would apply duty of candour and gave examples of types of complaints and incidents where it would apply.

Are diagnostic imaging services well-led?

Outstanding ☆

This is the first inspection using this methodology. We rated it as **outstanding.**

Leadership

- **The service had managers that demonstrated high levels of experience, capacity and capability to deliver a high quality and sustainable service.**
- **The leadership was integral to the drive to improve the delivery of high quality patient centred care.**
- **There was compassionate, inclusive and effective leadership at all levels.**
- The Pavilion clinic was jointly owned by BMI Healthcare and Global Diagnostics Ltd. Locally the service was managed by the imaging manager, who was employed by BMI Healthcare. All other staff worked for Global Diagnostics Ltd. The imaging manager reported directly to the senior management team from the Three Shires Hospital. Corporately, BMI Healthcare and Global Diagnostics Ltd, worked collaboratively to ensure the service functioned and all parties had oversight of performance.
- Corporate leadership was jointly provided by the BMI and the Global Diagnostic Ltd executive teams. We were told that representatives from each party sat on the other organisations board. This meant that representations were consistent. Despite the service being part of two organisations, they worked collaboratively to provide a seamless service.

Diagnostic imaging

- Local leadership mirrored the BMI corporate structure with a general manager supported by a director of clinical services, quality and risk manager and director of finance. They were reported as being visible and had oversight of service delivery and monitored performance. The imaging manager reported directly to the senior management team (SMT).
- The imaging manager worked across outpatients and imaging. They were supported by the clinical lead radiographer, clinical lead MRI radiographer and administration team lead.
- The imaging manager had embedded a system of leadership development, which included succession planning. Team leaders were being supported to develop into their roles, with clear career plans in place. There was a joint vision of what was needed to ensure that the service succeeded and staff were encouraged to be innovative.
- Locally, leaders were inspiring and strived to deliver a quality service and motivate staff to succeed. We were given multiple examples of how staff had been encouraged to develop and gain new skills. For example, the administration manager had started in the organisation as a receptionist. We were also told of staff who had worked as healthcare assistants, who had been encouraged to complete radiography training and were planning to return to the service as qualified radiographers following a period of consolidation.
- The imaging manager was visible, and regularly engaged with staff during their shift.
- We saw that the heads of each modality were being supported to develop into their managerial roles. The imaging manager met regularly with the heads of department and offered clinical supervision in addition to monthly one to one meetings. The imaging manager received monthly clinical supervision from the director of clinical services.
- Clinical supervision sessions in response to incidents were also completed by the director of clinical services. We saw that staff signed to confirm attendance to these sessions.
- Managers were provided with formal management training. Masterclasses were also attended by the team leads and imaging manager.

Vision and strategy

- **The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.**
- Strategies were in place to ensure delivery of service and develop the positive culture. There was a clear strategy to use innovation to improve the service deliver.
- The service had a five year vision 2015-2020 which was based on eight strategic objectives and priorities. This included topics such as people, patients, communications, growth, efficiency and information. Within these topics there were objectives. For example, within information, the objectives were to complete the integration of IT systems, complete monthly audits and ensure compliance with general data protection regulation. With regards to patients, objectives included the embedding of “hello my name is”, embedding the THINK customer principles and obtaining patient feedback through forums and questionnaires. During inspection, we saw that some of these objectives had been embedded. Staff were familiar with the vision and were actively participating in ensuring it was achieved.
- The local vision was embedded into the wider hospital plans, and we saw that the two area worked cohesively to ensure that the vision was appropriate and achievable. For example, there was an objective to review theatre utilisation of the image intensifier. This aspect relied on the joint working of the theatre manager and the imaging manager.
- We saw that plans were consistently implemented to improve the service and impact on quality and sustainability. For example, we were given examples of new treatments and external engagement that promoted the service and encouraged development.

Culture

Diagnostic imaging

- **Managers across the service inspired a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Leaders had a shared purpose, strived to deliver and motivated staff to succeed.**
- We saw that all interactions were completed in a positive, friendly and respectful manner. People spoke highly of each other and clearly valued each other's opinions. We saw that staff were given the opportunity to voice any concerns.
- The culture promoted professional development, and we were given examples of internal and external training events which were completed by all levels of staff. For example, medicines management training was completed by all radiographers and regular training away days were held for staff groups.
- Non- clinical staff were encouraged to observe clinical procedures to enable them to have an understanding of the procedures that they were booking patients for. Administration staff told us that this had benefitted them as they were able to answer queries from patients and offer them additional support if they were particularly anxious when arriving for their appointments.
- Staff were observed to work together for the benefit of the patient. For example, we saw that the daily "huddle" had been discussed as the timing had coincided with some patients' appointments which meant that not all staff could attend. The team had therefore agreed to change the time to enable all staff to be present.
- **There were high levels of staff satisfaction across all groups. Staff were proud to work for the organisation and spoke highly of the culture.**
- There was a strong organisational commitment and staff told us they enjoyed working for the service. They felt encouraged to participate in developing the service and felt able to speak openly about their thoughts and ideas. Staff were positive about the organisation and their role within it.
- There was a strong collaboration between the service and the wider hospital. The service participated in the hospital health and wellbeing programme, which had been accredited. Staff told us that there had been a focus on physical and mental health and the hospital had completed weekly activities which included exercise sessions, healthy eating, meditation sessions and massages. Staff told us that they participated in most of the activities and that the programme had helped them to feel more positive.
- The heads of department had completed personality testing which had helped them to identify how they worked. Staff reported that this process had helped staff to understand how people thought, and promoted greater understanding of individuals' priorities. Staff said this had helped promote a positive working environment. The team were planning to complete personality tests on each member of staff to help identify how the team could work more cohesively.
- The service provided training for a number of staff, which included IR(ME)R training for non- medically qualified referrers and radiation awareness training for theatre staff and new substantive staff.
- Staff received any updates or news through emails or a monthly newsletter. The newsletter celebrated any positive stories and shared any key information relating to the service or organisation. Staff told us that these were attached to payslips to ensure receipt.
- BMI completed annual staff surveys. We were provided with a copy of the 2017 survey results, however, these were not broken down into each service and represented the whole hospital. Data showed a staff engagement score of 66/100, which was an improvement on the previous year and better than the average BMI score of 56/100. The 2018 survey had been completed, but results were not available at the time of inspection.

Governance

- **The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.**
- The governance structure reflected the corporate structure, with information being shared to the most appropriate committee. For example, risk registers

were reviewed as part of the corporate governance and risk committee meetings. Below the corporate level, there were regional committee meetings which were attended by the local leadership team.

- Locally, meetings mirrored the corporate structure. This process enabled the senior management team (SMT) to have oversight and monitor performance.
- We saw that the service produced a monthly report which identified performance against a number of performance indicators. For example, the number of complaints, incidents, audit compliance, sickness levels and training compliance. The performance was then collated and compared to peer services. This enabled the SMT to determine areas for improvement.
- The service had representation on the hospital Medical Advisory Committee (MAC), with the lead radiologist attending meetings to escalate any concerns, discuss service delivery plans or offer specialist advice.
- The service held regular team meetings for non-medical and medical staff. Minutes showed that meetings were inclusive and followed set agendas, looking at performance, targets, any incidents or complaint that had occurred. Minutes showed that meetings were well attended.
- We reviewed a selection of minutes for different meeting and found that they were all detailed, followed a set agenda and outlined any actions to be taken in response to discussions. All meetings evidenced a review of actions and previous meeting minutes. Meetings appeared to be well attended with representation from administrative, clinical, medical and management.

Managing risks, issues and performance

- **The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. There was a consistent approach to overseeing compliance with requirements such as training and equipment maintenance.**
- **Governance and performance management arrangements proactively reviewed and reflected best practice.**
- There were robust processes in place to ensure the service ran smoothly. Performance was monitored through audits, compliance with targets and ad hoc senior management visits. Risks were regularly assessed and recorded.
- The service used risk assessments to record risks and any mitigation in place. For example, we saw a risk assessment relating to the exposure to radiation during investigations. Mitigation recorded included the use of screens, restricted access and warning lights to prevent entry to rooms.
- There was a local risk register which outlined two risks. Potential IR(ME)R incidents and the inability to integrate IT systems. Both risks showed mitigation and a consequential reduction in risk scores to low and very low. The risk register also detailed six closed risks. These included recruitment, investment in critical equipment, poor information security and preventable death or injury. These incidents showed mitigating actions and closure dates.
- The hospital risk register was held centrally by the senior management team and recorded risks with a score greater than eight. There were no risks identified on the hospital risk register that referred to diagnostic imaging.
- There was guidance on the frequency of risks being reviewed. For example, medium risks were reviewed a minimum of quarterly, and high risks a minimum of monthly. Risk registers showed that all risks had been reviewed in line with guidance.
- There was an extensive audit calendar which had been developed by the quality and risk manager. Previously the audit calendar for imaging had not contained many audits, however the team had collectively agreed to add audits to the annual programme. We saw that audits were spread across the year to even out the workload. Audits fell into three categories. Category one referred to mandatory audits such as infection control and prevention and WHO checklist. Category two referred to those against BMI standards, these included peer reviews and cross service audits. Category three referred to all local service specific audits.

Diagnostic imaging

- The imaging manager was provided with a monthly report which detailed the results of previous audits, and the details of those to be completed. The tools for reporting were also shared to ensure staff knew how to complete the programme.
- Results were collated and shared with the corporate team, and a performance dashboard generated. This enabled local managers to be held to account for performance and compliance. We saw that the service achieved 100% in almost all audits. The one audit which had not been 100% achieved was for hand hygiene (97%) and an action plan had been produced to ensure compliance.
- The quality and risk manager had oversight of all actions proposed from incidents and audits. We were told that the service had to evidence that actions had been taken prior to them being signed off as complete. We saw that actions were amalgamated onto a spread sheet for ease of tracking and evidence was recorded as it was provided.
- The Radiation Protection Advisory (RPA) Audit was completed annually. We saw that this was discussed as part of the radiation protection committee, clinical governance and heads of department meetings. This ensured that all relevant persons were up to date with the actions being taken to ensure radiation safety.
- The quality and risk manager shared all appropriate Medicine and Healthcare products Regulatory Agency (MHRA) alerts to ensure that items were not in use.
- We saw that equipment was regularly serviced to ensure that if was safe to use. Staff also told us that in the event of a fire alarm, patients would continue with their MRI investigation and staff would identify if there was a need to evacuate before suspending the investigation. The process was clearly recorded and the fire marshals were aware of the process.

Managing information

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- There was an on-site IT manager from Global Diagnostics Ltd at least one day per week. This person worked alongside the clinical team to manage information and the electronic systems in use. The IT manager was the senior information risk owner (SIRO) for the organisation.
- The SIRO attended any relevant BMI meetings to ensure a cohesive approach to IT across the two organisations. They reported that there was an effective relationship between the two organisations.
- The IT manager worked with the team to develop a process for sharing investigation images electronically with patients. The project was unique to the service and was planned to be rolled out across the organisation once effectiveness had been determined. The system was introduced following changes to general data protection regulation (GDPR). Previously, patients were supplied with encrypted CDs.
- There were systems in place to enable consultants to review images remotely. These were secure portals with individualised log ins. This meant that consultants were able to review images if they were seeing patients at other locations.
- Consultant radiologists received daily lists of images that required a review. This meant that there was a clear process for ensuring that images were reviewed in a timely manner.
- There were two systems used by the team. One was used to complete the investigations and the other predominantly for billing. The team were working on a system that would enable the information to be merged to prevent duplication. In the interim, an audit was completed of all patients' records on a monthly basis, to ensure that there were no discrepancies between the two systems.
- The service vetted and standardised the information being shared on the electronic database. This was to ensure that staff used the correct terminology for investigations, and promote consistency. The system was used to produce patients' bills, and therefore a systematic approach to identifying the investigations completed was essential.
- Staff were able to access old images as all information was stored at a central server. This meant that images and information could be obtained even if the local systems were not functioning.

- The IT manager completed a monthly audit of all images to ensure that all patient identifiable information was recorded on the image. Any omissions were highlighted to the booking team for correction. This process meant that images could be accessed by the hospital number, name or address.

Engagement

- **The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services. They worked collaboratively with partner organisations effectively.**
- BMI and Global Diagnostics Ltd worked collaboratively to ensure that the imaging service was effective. We were told that there was representation on each board and joint working to deliver projects.
- The service supported the local mental health hospital to provide magnetic resonance imaging (MRI) scans for research projects being completed. The team supported the memory clinic for sequence specific MRI brain scans.
- The service worked collaboratively with the hospital to participate in local events with charity organisations. For example, coffee mornings to raise funds for local charities.
- The service also engaged with a number of external organisations. For example, a university used the service as a placement for radiography students. The service also participated and arranged local events for GPs to promote their services and offer specialist training.
- Consultant radiologists provided case reviews as training exercises for the service. We were told that topics were chosen in advance and sessions could be attended by anyone. Staff reported that these sessions had been beneficial and that they had learnt from the discussions and topic choice.
- Staff told us that they actively requested feedback form external parties and used this to develop the services.
- Patient feedback was captured through comment cards and patient satisfaction surveys. The service also participated in the hospital patient focus groups.

Learning, continuous improvement and innovation

- **The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.**
- **Safe innovation was celebrated. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care.**
- There was a quality and efficiency improvement plan for 2018/19 which included a focus on utilisation of services to improve treatment and care. There was a focus on the implementation of multi-skilled workers, particularly within x-ray.
- The service had commenced multi-parametric (MP) MRI prostate scanning in response to the identification of this procedure being beneficial to patients and not readily available. MP MRI scanning is a procedure used to identify prostate cancer and is less invasive and less painful than previous procedures.
- MP MRI scanning was introduced using following a search of relevant literature and liaison with specialists. New procedures were required to be authorised before commencing, and extensive training was required once approval was granted. The service is the only location that this type of testing is available in Northampton. Patients were reported as travelling from outside the county for this procedure to be completed.
- In response to the development of MP MRI scanning, the team liaised with a local prostate cancer support group to discuss the procedure and have helped to organise a men's' health BMI GP event.
- The service was being used as a pilot site for the merging of the two electronic databases. Staff were actively assisting with the development of the system which would enable databases, imaging and billing to be merged to one database to prevent duplication in results. Staff planned to introduce the new system before rolling it out to the rest of the organisation.
- The hospital had been the first BMI hospital to achieve accreditation for health and well-being.

Outstanding ☆

Diagnostic imaging

- The service was working on other projects which included the development of MRI small bowel imaging which would enable the move from radiation based investigations.

Outstanding practice and areas for improvement

Outstanding practice

- We saw that the interventional list was managed by a radiologist and a radiographer, which was unusual. These lists are normally managed by a radiologist supported by a healthcare assistant. This process was above expectation.
- All referrals were contacted by the booking centre within 24 hours of receipt of the referral. Appointments were allocated for an appointment slot that met the needs of the patient. This process was consistently for all patients irrespective of whether they were private or NHS funded.
- The majority of images were reported on within one day of the image being taken. All images were reported on within one week.
- Staff wellbeing had taken priority, with the service participating with the health and wellbeing accreditation programme.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that mandatory training is completed by all staff in line with service targets.