Leicester Nuffield Alliance MRI Unit

Quality Report

Nuffield Health Leicester 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	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.

Overall summary

Leicester Nuffield Alliance MRI Unit is operated by Alliance Medical Limited. The service has a reception area with an accessible toilet. Through the controlled access door, there is a clinical preparation area, patient changing room and toilet, staff changing room, the Magnetic Resonance Imaging (MRI) scanning room with a 1.5T (tesla) MRI scanner and a viewing/control room.

The service only provides diagnostic imaging through MRI scanning, therefore we only inspected diagnostic imaging.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 13 November 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.

Services we rate

We previously did not have the authority to rate this type of service, however now we do. We rated it as **Good** overall.

We found the following areas of good practice:

- There was a safety focused culture within the unit. Staff had a comprehensive policy to follow when identifying significant findings on the scan, as well as thorough use of the 'pause and check' flow chart prior to commencing a scan.
- There was a system and process in place for identifying and reporting potential abuse. Staff were supported by individuals with more enhanced training in safeguarding and there were clear channels of escalation which staff were aware of. Staff also had access to a paediatric nurse from the host hospital for when children and young people attended for scanning appointments.
- Clinical environments were visibly clean and tidy, and were suitable and appropriate to meet the needs of the patients who attended for appointments, as well as relatives and children who accompanied them.
- Staff had comprehensive corporate policies to follow which were based on evidence-based best practice and nationally recognised policies.
- There was a corporate audit plan in place which the service contributed towards, as well as completing local quality checks of scans and reports.
- Feedback from patients was positive during our inspection and we observed some examples of high quality care, from compassionate and professional staff.
- There was a strong teamwork ethic amongst the staff who directly worked within the MRI unit, as well as strong multidisciplinary team working with staff from the host hospital.
- The referral to scan and reporting times were well within the expected timeframes.
- There were processes in place to ensure the individual needs of patients were met.
- There were few complaints raised against the service, and the complaints which were raised were dealt with in line with corporate policy.
- Governance processes were well-embedded and there were clear channels for escalation of concerns and cascade of information from the top.

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

Summary of findings

- At the time of our inspection we observed low morale amongst staff. Staff told us this was due to the changes in management and the way it had been handled. Staff had previously escalated concerns and suggestions, however these had not been addressed or actioned.
- There were corporate policies and training in place for the management of medicines. However, there were concerns raised by staff about their roles and responsibilities regarding the checking and administration of intravenous contrast and self-administration of medicines.
- Paediatric life support training was well below the expected standard for the service and did not follow corporate policy. However, the service was supported by a resuscitation team and paediatric nurse from the host hospital.
- There were no processes in place to enable staff to undergo clinical supervision and staff reported not having the opportunity to complete continuous professional development and training requirements due to limited staffing.
- The service did not formally record waiting times on the day of appointments, despite there being a delay on the day of our inspection.

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

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	Diagnostic imaging, more specifically the provision of Magnetic Resonance Imaging (MRI) scanning was the only service provided at this location. We rate this service as good overall because patients were protected from avoidable harm and abuse. Care and treatment was provided based on best practice and provided by competent staff. Feedback from patients was positive and we ourselves observed positive examples of compassionate care. Patients could access care and treatment in a timely way and there were flexible appointment times to meet patient needs. There was a vision and set of values which staff were aligned to and governance processes were in place to provide adequate assurance of service provision.

Summary of findings

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Diagnostic imaging.

Summary of this inspection

Background to Leicester Nuffield Alliance MRI Unit

Leicester Nuffield Alliance MRI Unit is operated by Alliance Medical Limited. The static service opened in 2014 and replaced the original mobile provision which visited the host hospital. The service accepts patient referrals from the immediate area as well as patients living outside this area.

The service currently had a registered manager of another location overseeing this location until the new unit manager had completed the registration process. Prior to the new manager commencing, there was two previous registered managers in post from when the service opened in September 2014.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, an assistant CQC inspector and a specialist advisor with expertise in diagnostic imaging. The inspection team was overseen by Simon Brown, Inspection Manager.

Information about Leicester Nuffield Alliance MRI Unit

The department had one magnetic resonance imaging (MRI) scanner and is registered to provide the following regulated activity:

- Diagnostic and screening procedures.

During the inspection, we only visited the MRI unit which was located on the ground floor of the hospital. The hospital itself was ran by another provider who we did not inspect at this time. We spoke with five staff including; radiographers, clinical assistants, administrative staff and senior managers. We spoke with three patients on the day of inspection and reviewed three sets of patient records (scans and reports).

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 not been inspected since it was first registered with the CQC in August 2014.

Activity (August 2017 to July 2018)

- In the reporting period August 2017 to July 2018 there were 5,073 MRI scans completed by the department; of these 14% were NHS-funded and 86% other funded.
- In the reporting period August 2017 to July 2018 there were 85 scans performed on children and young people (age range eight to 18 years old).

The service employed one unit manager, one radiographer who was also the lead radiographer for the service, one clinical assistant and three administrators, as well as having access to its own bank staff. There was no accountable officer for controlled drugs (CDs) as the service did not use controlled drugs.

Track record on safety

- Zero never events
- Ten clinical incidents nine low harm and one moderate harm.
- Zero serious injuries
- Four complaints, all of which were upheld.

Services accredited by a national body:

- Imaging Services Accreditation Scheme, July 2018, due for renewal July 2021.
- ISO 27001-Information Security Management Accreditation, June 2018, due for renewal June 2021.

Summary of this inspection

- Investors in People (IIP) Accreditation, March 2017, due for renewal March 2020.

Services provided at the unit under service level agreement:

- All waste removal (except confidential waste)
- Cleaning provision
- Interpreting services
- Grounds Maintenance
- Laundry
- Maintenance of building facilities
- Pathology and histology
- Resident Medical Officer (RMO) provision

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **Good** because:

- There were processes in place to ensure patients were protected from avoidable harm and abuse. Staff knowledge of safeguarding was strong and there were clear processes for escalation.
- The MRI unit was visibly clean and tidy, and staff followed correct infection prevention and control practices when providing care and treatment to patients.
- There was a process in place for staff to follow when escalating significant pathology/findings from the MRI scan. Staff were knowledgeable of this process and could give examples of when they had needed to do this.
- Staff adhered to recognised safety checks when performing a MRI scan on a patient. All staff used the 'pause and check' checklist prior to completing a scan on a patient.
- Staff took patient and staff safety seriously in the department. All patients, staff and visitors completed a safety checklist prior to entering the MRI room. The department also routinely practiced cardiac arrests scenarios to ensure a seamless response to emergency situations.
- There was an incident reporting policy and procedure in place which all staff were aware of. The service had a positive approach to incident reporting and learning from all incidents, regardless of level of harm.

However:

- Despite corporate medicines management policies and medicines mandatory training, staff voiced concerns about their roles and responsibilities in relation to the checking and administration of intravenous contrast and patients self-administering benzodiazepine within the scanning room.
- Paediatric life support training was well below the expected standard for the service and did not follow corporate policy. However, the service was supported by a resuscitation team from the host hospital.

Are services effective?

We do not rate effectiveness.

Summary of this inspection

- Policies, procedures and guidance was based on national policies, legislation and best practice guidance including those released by bodies such as National Institute for Health and Care Excellence (NICE) and the Society and College of Radiographers.
- The service participated in the corporate audit programme as well as local auditing including quality audits of scans and reports.
- There was strong multidisciplinary team working between staff in the MRI unit and staff from the host hospital.
- Staff were knowledgeable about the Mental Capacity Act and consent requirements, especially the requirements around Gillick competency.

However:

- There were no processes in place for staff to complete clinical supervision. Staff also indicated there was little opportunity for them to develop their roles further through continuous professional development and role specific training.

Are services caring?

Good

We rated caring as **Good** because:

- Patients we spoke with were all positive about the service they received and the staff who provided the service. Our own observations during the inspection supported positive interactions between staff and patients.
- Staff treated patients with dignity and respect at all times, and endeavoured to ensure the confidentiality of patients
- Staff provided emotional support to patients when required and were able to provide examples where they had done this.
- There were systems in place for the service to collect patient satisfaction and feedback on a regular basis through the use of the friends and family test (FFT). Results from the FFT were constantly in the high nineties with the most current compliance rate recorded at 100%.

Are services responsive?

Good

We rated responsive as **Good** because:

- The clinical environments were suitable and appropriate to meet the needs of the patients.
- The service made a concerted effort to meet the individual needs of patients. For example, interpretation services were available for patients whose first language was not English and staff knew how to access this.

Summary of this inspection

- The service had a positive approach to the complaints they received (which were low in numbers) and the management of complaints.
- The service had low numbers of patients who did not attend for their scans or cancelled at short notice. This was monitored through the quality score card each month.

However:

- The service did not provide a range of appointments times and dates to meet patient need. Scans were only available Monday to Thursday, with times no later than 7pm.
- The service did not locally monitor 'on the day' waits despite the service running behind on the day of our inspection. Staff however told us this was rare.

Are services well-led?

Good

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

- Governance systems were in place which all staff were aware of and involved in. There was evidence of information and issues being escalated upwards, as well as information being cascaded downwards through the system.
- There was a process in place to identify and assess risks in the service, with ongoing monitoring of them through the governance system.
- There was a corporate vision and set of values in place which staff were aware of and aligned to.
- There was locally good team work and team ethic amongst the frontline staff. All staff were supportive of each other and trusted each other.

However:

- There were some local cultural issues in the unit since the appointment of a new manager. There was recognition that this had impacted morale of staff and this was only just beginning to improve.
- Staff had previously escalated some concerns and suggestions for improvements to the service, however these were not listened to and no action taken. This had impacted the perceived approachability of managers and engagement of staff.
- All staff participated in the corporate staff survey, however there was no feedback to local teams about the satisfaction of staff.

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

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients and diagnostic imaging services safe?

Good

We previously did not have the authority to rate this service. However, on this inspection we did have authority to rate and we rated it as **good.**

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Staff were required to complete mandatory training modules on mainly an annual basis in basic life support, complaints handling, conflict resolution, equality and diversity, fire safety at work, health and safety, infection control, information governance, managing violence and aggression, manual handling objects and safeguarding vulnerable adults and children level one training. Clinical staff were additionally required to undertake immediate life support, medicines management in imaging, moving and positioning people and patient handling. All levels of safeguarding training were required to be completed on a three-year cycle. Mandatory training was a mixture of face-to-face learning and electronic learning.
- Local training information showed 100% compliance with most of the mandatory training modules, with the only exceptions being conflict resolution (83%) and managing violence and aggression training (83%). The compliance target for mandatory training was 90%, this was an Alliance Medical Limited corporate compliance figure.
- Paediatric life support training was also a requirement for staff at this location as they provided care and treatment for children and young people. The corporate policy for the management of medical emergencies identified all staff would require some level of paediatric life support, with the basic level identified for most job groups. This was in confliction with the corporate training needs analysis for mandatory training which suggested only qualified staff in the department required paediatric life support training (paediatric immediate life support training recommended). Local training records showed only one clinical member of staff (17%) had paediatric life support training in the department. This member of staff was always on duty when children and young people were present in the department.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.** Staff had training on how to recognise and report abuse and they knew how to apply it.
- There was a corporate lead for safeguarding children who was trained to level four. Staff were aware of the corporate lead for safeguarding and would access them for support and advice if required. Staff in the department also had access to the host hospital's safeguarding team for support and advice if required.

Staff told us there had been no safeguarding concerns at this location, however there had been learning shared from a safeguarding concern raised at a different location.

- There was a safeguarding vulnerable adult's policy in place which was dated May 2018. The policy provided staff with information about what constitutes abuse and advice on what to do in the event of a concern. The policy referenced The Care Act 2014 which sets out the statutory responsibility for staff regarding safeguarding which superseded the 'No Secrets' document. There was evidence of previous amendments to the policy and a review date identified.
- There was a safeguarding children policy in place which was dated March 2018 and had a review date identified. The policy provided staff with information about what constitutes abuse and specific concerns around child protection and child safety (including female genital mutilation). This policy also included information about radicalisation and modern-day slavery, including signs for staff to be aware of.
- All staff were required to undertake vulnerable adults safeguarding training and level one safeguarding children training. Local training information showed 100% compliance with both of these training requirements. Level two safeguarding children training had been completed by both clinical staff in accordance with the intercollegiate document for 'safeguarding children and young people: roles and competences for health care staff'. In addition to this, one of the clinical staff had also complete level three safeguarding children training. This provided the department with a local resource of more in-depth knowledge and skills when it came to recognising and responding to safeguarding concerns involving children and young people.
- Staff at this location had access to a children's nurse through the host hospital provider. When any young child was due for a scan, the children's nurse would attend the department whilst they underwent their scan. For older children, the children's nurse would only physically attend at the request of the staff in the MRI unit, but would always be contactable for advice, guidance and support if required. The request for them to attend would be dependent on both the age of the young person and their presenting medical condition.
- Staff from the service followed the host hospitals procedures for the management of suspected non-accidental injuries in children and young people. If there were concerns identified during a scan, staff would immediately escalate this through the host safeguarding team and notified the corporate safeguarding lead. Staff told us since the service had operated from the hospital, there had been no non-accidental injury concerns escalated.
- Staff were aware of the concerns around female genital mutilation (FGM) and had access to a flow chart for escalating concerns if identified. Female genital mutilation/cutting is defined as the partial or total removal of the female external genitalia for non-medical reasons. Since October 2015, it is mandatory for regulated health and social care professionals to report known cases of FGM, in persons under the age of 18, to the police. There were four types of FGM which healthcare professionals are required to report.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well.** Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- There was a corporate lead for infection prevention and control (IPC). An annual IPC report was produced which covered areas of hand hygiene, insertion of peripheral cannulas, annual IPC audit, IPC related incidents and patient pathway for potentially infectious patient.
- There were handwashing facilities within the clinical environment and staff had access to alcohol hand gel at point of care. We observed staff performing hand decontamination in accordance with the World Health Organisation (WHO) five moments for hand hygiene. We also observed hand hygiene promotional posters to support compliance with hand hygiene. All staff were observed to be bare below the elbow on the day of our inspection.

- The service conducted local IPC audits which included hand hygiene audits and cleanliness audits. This was the responsibility of the lead radiographer. All recent audits demonstrated 100% compliance. Information from these audits were discussed during corporate governance meetings, as well as relevant items (cleanliness specifically) being included in a report to the host hospital provider.
- Staff told us the host hospital was responsible for the cleaning of the environment. If there were any complaints regarding the cleaning, they would escalate this to the host provider and action would be taken immediately. Cleaning schedules were in place in the department, and these were completed.
- There were wipes available in the department for staff to decontaminate equipment after use. We observed staff wiping down equipment after this had been used to prevent the potential transmission of infection between patients.
- Staff had access to personal protective equipment (PPE) in the MRI unit to protect themselves and patients during care and treatment.
- The lead radiographer was trained to complete cannulation and intravenous (IV) therapy administration using the recognised Aseptic Non-Touch Technique (ANTT). The clinical area where cannulation and IV therapy administration took place had ANTT posters and sharps safety posters displayed to remind staff of the correct technique.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well**. The department had been open for four years and was still in a good state of repair. The layout of the unit was compatible with the health building note 06 (HBN 06) facilities for diagnostic imaging and interventional radiology. There was a spacious reception with an accessible toilet, a clinical room, a patient changing room and toilet, the scanning room and a control room. The changing room had patient lockers which were used whilst the patient underwent their scan, the keys for these lockers were made of materials (non-ferromagnetic) which could be taken into the scanning room with the patient.
- There was an emergency 'quench' switch located in the department. Quench is the process where the liquid cryogens cooling the magnets in the scanning equipment are rapidly released, causing helium gas to be released and stops the magnets from working. The emergency quench switch was protected from accidental use. In addition to this, there were emergency off switch available which suspended scanning activity or temporarily suspended the magnet sub-system, but did not quench the magnet.
- The scanning room had an oxygen monitoring system in place, as recommended in the HBN 06, point 13.64. This ensured if there was a helium leak from the cryogenic Dewar which was escaping into the scanning room, this would be identified prior to compromising patient safety.
- In the area where the magnetic resonance imaging (MRI) equipment was located, there were signs to indicate the dangers associated with this and prohibition signs. The strength of the MRI scanner was clearly displayed on the signs. This practice was in line with the Medicines and Healthcare Products Regulatory Agency (MHRA) safety guidelines for magnetic resonance imaging equipment in clinical use 2015.
- All equipment belonging to the service was labelled in line with MHRA recommendations e.g. MR Safe, MR Conditional, MR Unsafe. This ensured all staff knew which items could and could not be safely taken into the scanning room and reduced the risk of items accidentally being taken in and becoming a projectile. If staff were unsure if items were MR Safe or MR Unsafe, they would treat them as unsafe until proven otherwise.
- Staff in the MRI department had access to an adult and paediatric resuscitation trolley in the event of a medical emergency, which also contained an anaphylaxis kit. All equipment on both the trolleys was checked and maintained by staff from the host hospital. We reviewed the trolley during our inspection and found it was signed as being checked regularly (apart from when the department was not open) and items were in date. The trolley itself was sealed and tamper proof. As this equipment did not belong to the service, there was no clear signage on the equipment to identify that it was MR unsafe and therefore could

not be taken into the scanning room. The service did not have a process in place at the time of our inspection for receiving assurance of its functionality and readiness.

- There were emergency alarms throughout the department which also had a visual panel to identify where the emergency was. This system linked to the rest of the host hospital so in the event of an emergency, all staff working throughout the hospital would be aware.
- The service had access to a first aid box which contained a small supply of items for minor injuries. All items within the first aid box were in date and there was a checklist to support regular checking of this item.
- The service had a wheelchair and trolley which were both MR safe and could be taken into the scanning room.
- There was a system in place to ensure all equipment was serviced and maintained in accordance with manufacturer guidance. We found all equipment had evidence of a service and there was evidence of daily checking of all machines. In the event of an equipment failure, the external company who provided the equipment would be contacted to repair the equipment.
- All equipment in the MRI unit had evidence of in date electrical safety tests.
- We observed staff correctly segregated clinical and domestic waste. Waste bins provided for the department were enclosed and foot operated. Sharps bins were correctly assembled and below the fill line. The management and disposal of sharps and waste was completed in accordance with policy. Domestic and clinical waste was collected and disposed of by the host hospital as part of a service level agreement.
- The service was responsible for ensuring confidential waste was disposed of correctly. This was completed through a contract with a confidential waste specialist company.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient.** They kept clear records and asked for support when necessary. All patients and visitors were required to complete an MRI safety checklist prior to receiving a scan. This asked the patient (or visitor) if they had a pacemaker, any prosthesis, any metal fragments in their eyes or for females, was there a possibility they may be pregnant. During our inspection, we were asked to complete one of these forms before progressing beyond the reception area.
- All patients who required intravenous contrast during their scan underwent a specific blood test (estimated glomerular filtration rate- eGFR) to ensure their kidney function was satisfactory prior to having this administered. Some of the contrast used during imaging procedures can induce acute kidney damage, it was therefore essential for staff to understand a patient's normal kidney function prior to administering this. The host hospital had point of care testing for this which enabled a fast turnaround on results. Radiologists or the RMO (resident medical officer) would be responsible for reviewing the results of the blood tests prior to prescribing the contrast for a patient to ensure they were safe to undergo the procedure.
- All patients and visitors were informed of any relevant safety procedures which included the nearest fire exits and meeting point.
- There were local rules available for staff to follow which were kept on the computer system which all staff had access to. The service was also supported by a medical physics expert who was external to the service. However, not all staff were aware who this was or how they could contact them.
- The service ensured that the 'requesting' of an MRI was only made by staff in accordance with IR(ME)R guidelines. The referral forms included patient identification, contact details, clinical history and examination requested, and details of the referring clinician/practitioner. All referrals were reviewed by radiologists prior to patients having appointments confirmed.
- There was a policy in place to transfer patients to the nearest acute hospital in the event of a medical

emergency. During the period of August 2017 to July 2018 there were no medical emergencies recorded which required transportation out of the service. All staff were aware of this process.

- In the event of a patient expressing they felt unwell (but not considered a medical emergency/patient had not collapsed) the staff had access to the host hospital resident medical officer (RMO) who would attend to review the patient. For paediatric patients, if the children's nurse was not already present, staff would contact them to review the patient.
- The service had a significant pathology procedure document which guided staff on the actions to take in the event of identifying unexpected findings/ pathology. If staff found any concerns around the scan results which required urgent intervention, staff would arrange for the patient to be transferred to the nearest acute hospital with copies of all scans and a report from the radiologist.
- Staff in the department used the Society and College of Radiographers 'pause and check' document. This ensured all staff went through a safety checking procedure to ensure the right patient received the right scan of the right anatomical area. We observed staff completing this during our inspection.
- Staff told us they frequently practiced the cardiac arrest procedure with staff from the resuscitation team at the host hospital. Staff within the department were responsible for evacuating the patient from the scanning room, whilst the host hospital staff brought the resuscitation equipment to the patient. A recent practice was undertaken and staff recorded the time taken for the resuscitation trolley to arrive at the arrest, this was 73 seconds from initial sounding of the alarm. Staff in the department fed-back to the resuscitation team of the host hospital about concerns over some staff not understanding the implications of why the trolley could not be taken into the immediate scanning room and suggested this be included in future resuscitation training.
- The service did not formally undertake manual handling risk assessments for patients attending for scans, however,as part of the booking process each patient was assessed for mobility and if patients required assistance on the day, this would be identified through the MRI safety checklist. Any manual handling risks identified would be addressed in the department and all staff would help patients to move around the department as required. However, training records identified only clinical staff had patient focused manual handling training, although all staff regardless of role within the department told us they would be involved in helping patients in the department.

Radiography staffing

- **The service had staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- The service used a 'staffing requirement in support of a safe scanning pathway' alongside a staffing calculator to ensure staffing levels in the department were always safe. Usual daily staffing for the department (on days when scanning was undertaken) was one lead radiographer and one clinical assistant. An administrative assistant would also work in the reception area. On non-scanning days, the administrative assistant would be in the department on their own. There was a lone worker policy to support this, although staff from the host hospital would be working in the immediate vicinity of the MRI department.
- There were six members of staff employed at this location. One-unit manager on a part-time basis, one lead radiographer and one clinical assistant who were both full time employees and three administrators who worked on a part time basis.
- The provider had an agency framework which staff were expected to be part of. This framework was used to cover any short notice staffing vacancies due to sickness. Information provided by the service showed there had been two radiographer shifts, two clinical assistant shifts and 17 administrator shifts covered by bank staff between May 2018 and July 2018. For the same period, there had been 11 radiographer shifts and six clinical assistant shifts covered by agency staff.

Medical staffing

- The service did not directly employ any medical staff at this location. Staff did however have access to radiologists externally within the wider corporate community, as well as an onsite radiologist who worked for the host hospital.
- Staff had access to the resident medical officer (RMO) who worked for the host hospital. They were available for the core working hours the service opened for.

Records

- **Staff kept detailed records of patients' care and treatment.** Records were clear, up-to-date and easily available to all staff providing care. We reviewed three reports and MRI scans and found all scans were clear and of acceptable quality. The reports were clear, written in a timely manner and of a high quality.
- The service used three separate electronic systems for patient records, two systems held clinical information and one system was purposely for administrative purposes only.
- Reports from patient scans were completed by reporting radiologists in a timely manner and sent electronically to the referring clinician. For patients who were accessing a scan under an urgent referral, reports would be forwarded to the referring clinician within 24 hours of the scan. If urgent medical attention was required, this was immediately reported on and a copy of the report sent with the patient to the local acute hospital. All other reports aimed to be sent within three days of the patients scan. The service was currently producing reports within five days of the patients scan.
- The service regularly audited the quality of the scans which were produced. The most recent audit conducted in January 2018 showed scans were mainly graded of 'good' quality. Sixteen scans were included in the audit, there were five scans which had an element within them graded as adequate. Additional comments recorded showed this was mainly due to patients moving whilst undergoing the scan. Feedback from the host hospital radiologist who regularly reported on the scans conducted was largely positive, with no concerns being raised about the quality.
- Patients personal data and information were kept secure and only staff had access to that information. Staff received training on information governance and records management as part of their mandatory training programme.

Medicines

- **The service followed best practice when prescribing, giving, recording and storing medicines.** Patients received the right medication at the right dose at the right time. Medicines were stored in lockable cupboards which were temperature controlled. The temperature was regularly monitored and staff knew what actions to take if the temperature was recorded outside of the normal range.
- The service did not hold any controlled drugs, and therefore had no controlled drugs accountable officer. The lead radiographer was the services own lead for the safe and secure handling of medicines.
- The service had access to a pharmacy advisor for medicine management support. A corporate medicines management policy was available to staff on their electronic systems, which included information about medicines management issues for imaging procedures not relevant to the service. Staff told us there was no locally adapted medicines management policy.
- The service used patient specific directions (PSDs) for the administration of intravenous contrast. These prescriptions were written up after the patient had undergone the eGFR specific blood test by the radiologist or RMO.
- All clinical staff completed a medicines management in imaging module to increase their awareness in the correct processes and procedures. This included information about administration of medicines, administration of contrast, reporting adverse reactions and patients self-administering medicines. It was noted the self-administering of benzodiazepines included in this training related to those patients undergoing a different imaging procedure (positron emission tomography-computerised tomography PET-CT) and not MRI scans.
- Staff told us patients were encouraged to self-administer medicines prior to arriving at the MRI

unit, this included all regular medications and medications specifically used to reduce patient anxieties (for example, diazepam). Patients who required inhalers for asthma and sublingual sprays for heart problems (for example, GTN-glyceryl trinitrate) were encouraged to bring these with them in case they required them during the procedure. However, staff also told us, patients had brought (and self-administered) diazepam whilst undergoing a procedure to help them remain calm throughout the procedure. The corporate medicines management policy contained details around self-administration of medicines, including diazepam, however this was in relation to alternative imaging procedures. The medicines management training which all clinical staff completed also provided staff directions on what they were expected to do/not do in these circumstances. Staff were not aware of any local guidelines in relation to patient self-administration of medicines and were not confident about their roles and responsibilities when patients self-administered medicines of this type on site.

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.
- There were no never events reported for the service from August 2017 to July 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 August 2017 to July 2018. Serious incidents are events in health care where there is potential for learning or the consequences are so significant that they warrant using additional resources to mount a comprehensive response.
- There were 10 incidents recorded from August 2017 to July 2018. One of these incidents was recorded as moderate harm and nine were low risk. The moderate harm incident was in relation to a patient who should have been referred on through the significant pathology pathway. Since this incident, the policy was updated and staff were now more empowered to escalate patients for urgent care and treatment. There was no trend or theme within the remaining nine low harm incidents. Senior staff told us there was a good reporting culture within the service, with staff now encouraged to report cases of claustrophobia (fear on enclosed spaces) which impact on the scan performed. Staff who reported incidents received feedback on them and all significant incidents were discussed at team meetings.
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. The duty of candour regulation only applies to incidents where severe or moderate harm to a patient has occurred.
- Staff we spoke with understood the duty of candour process and the need for being open and honest with patients when errors occur. Senior staff members were able to explain the process they would undertake if they needed to implement they duty of candour following an incident which met the requirements. Information provided by the service showed there were no incidents from August 2017 to July 2018 which required the duty of candour to be implemented in accordance with the regulation.
- Staff did tell us about an incident which involved a scan of the wrong limb which they had conducted. This incident was graded low harm as there was no harm caused to the patient from undergoing another MRI scan. However, the staff member told us they were involved in contacting the patient and apologised to them for the mistake. This process although did not require formal duty of candour implementation, followed the principles of the duty of candour.
- The corporate provider had recently implemented an incident newsletter called 'Risky business'. This

provided staff across the Alliance Medical Limited group the opportunity to discuss relevant incidents which had occurred and which could occur in their areas and learn from them.

Are outpatients and diagnostic imaging services effective?

We do not rate effective.

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 had access to corporate policies, procedures and guidance on their internal electronic systems. These were mainly based on current legislation, evidence-based care and treatment and best practice, which included policies and guidance from professional organisations such as National Institute for Health and Care Excellence (NICE) and the Society and College for Radiographers. Alliance Medical Limited reviewed relevant and current evidence-based guidance, standards, best practice and legislation at the clinical governance committee, which then fed into the integrated governance meeting.
- Local policies, guidance and rules were also completed and stored on the internal electronic system. At the time of our inspection, a local safety folder for the MRI unit was being reviewed by the lead radiographer.
- There was a corporate audit programme in place which the service participated in. Results from audits were discussed at the quarterly audit committee meeting.

Nutrition and hydration

- **Patients had access to enough hydration services to meet their needs.**
- All patients were offered complimentary drinks when they attended for their MRI scan. This included a selection of hot drinks and cold water. During our inspection, we observed the receptionist directing patients and their relatives to the drinks machines available.

Pain relief

- **Staff did not complete pain assessments for patients.** MRI scans were none invasive and were not painful for patients to undergo. Patients with known long-term pain management concerns would be identified during the referral process and encouraged to continue taking their analgesia (pain medication) as normal.
- During our inspection, we did observe staff asking if patients were comfortable during their procedures. Staff helped them into positions on the scanning table which made them as comfortable as possible.

Patient outcomes

- **The service had some processes in place to monitor the effectiveness of care and treatment in the unit.**
- The service completed a monthly quality score card which contained performance measures on referral to scan time, scan to report time, did not attend rates and patient engagement and satisfaction information. The information for October 2018 showed the service was currently scanning patients four days from referral and reports were completed within five days of the scan.
- Staff told us there were regular image quality audits completed and reports from these produced. From these reports, areas for improvement would be discussed and planned re-audits conducted if required. The audit conducted in January 2018 included 16 MRI scans, mainly of shoulder MRI scans. Results showed the scans were mainly of good quality overall, with only five scans having an element of 'adequate' rating within them.
- The service was also required to complete quarterly quality audits of scans for an external agency.
- The service had recently started to implement an average daily scanning target which was monitored by the unit manager as part of their performance targets. Information received by the service showed the

service had exceeded their average daily scanning target in July 2018, however due to machine failures, the service had dropped below their target for August 2018.

Competent staff

- **The service attempted to make sure staff were competent for their roles.** Information received from the service showed staff were all in date for their annual appraisals. However, due to recent changes in the management structure, staff told us there had been delays in on-going one to one meetings, which had impacted on applications being made for external training as well as previously identified developmental opportunities not being acted upon.
- Staff did not have any formal clinical supervision opportunities at the unit. There was only one radiographer who worked at this location and this impacted on their ability to fulfil requirements of clinical supervision or seek any debriefing opportunities in the event of a difficult scanning experience. Access and interaction with other Alliance Medical Limited staff was minimal which reduced other opportunities to complete any supervision. Opportunities for continuous professional development were also minimal, with staff reporting having been cancelled from attending training due to staffing shortages.
- Staff who required additional competency training in equipment or clinical skills had previously attended specialised training and details of competency were held on local staff files by the unit manager. Examples of additional competency achieved by staff at this location included contrast pump training, cannulation and intravenous therapy administration.
- The human resources (HR) for the corporate provider were responsible for ensuring staff held the right qualifications, skills, knowledge and experience to do their job when they started their employment, and were also responsible for ensuring staff remained competent in their role on an on-going basis. There was only one member of staff who was required to be registered on a professional register and details of their registration was recorded on their staff file held by the corporate HR.

Multidisciplinary working

- **Staff of different kinds worked together as a team to benefit patients.** Doctors, nurses and other healthcare professionals supported each other to provide good care.
- We observed the local team working well to provide safe and effective care and treatment for patients who required a MRI scan. All staff commented on how well they worked as a team despite being a small team.
- During our inspection, we also observed the local team working well with staff of all backgrounds from the host hospital. Feedback from staff from the host hospital about the team in the MRI unit was positive, with comments relating to good communication and good quality work (scans) being at the centre of their feedback. Staff from the MRI unit were equally as complimentary about their interaction with staff from the host hospital, and knew they could approach staff for advice and support if required.

Seven-day services

- The service did not provide seven-day services. The service was open between Monday and Friday, scanning procedures were completed between Monday to Thursday.
- The service did not provide an emergency scanning list, however staff told us there was an element of flexibility during each list which could accommodate patients requiring an urgent scan.

Health promotion

- Information leaflets were available for patients to inform them what to expect during their MRI scan as well as infection prevention and control leaflets. However, we did not observe any additional information in the MRI unit to support healthy living and lifestyle choices in line with national priorities.

Consent and Mental Capacity Act

- **Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.** They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. However, staff told us they would benefit from more in-depth training around the Mental Health Act

(1983) and their roles and responsibilities for supporting patients with mental health concerns, especially after an incident occurred at another location.

- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent. Staff were aware of the consent form for patients who were deemed to be lacking capacity but required an MRI scan. This would be completed by the referring clinician and staff at the MRI unit would review the consent on attendance to the unit. Staff told us they did not routinely have many patients who were assessed as lacking capacity, although they did see patients who were mildly confused and found to be developing conditions which were related to capacity problems (for example newly diagnosed Alzheimer's and dementia). For all patients attending the unit, staff would encourage them to bring a relative or friend with them, but would strongly encourage those patients with mild confusion or anxiety around the scanning procedure to bring someone with them.
- Mental Capacity Act (MCA) 2005 training was completed as part of mandatory (safeguarding vulnerable adults) training. All staff at this location had completed this training.
- All patients were required to complete a MRI scan risk assessment form when they attended for their MRI scan. At the end of this form, patients would be required to sign to give their consent to the scan going ahead. Clinical staff completing the procedure would check the details of the form when taking them to the scanning room and checked to ensure they were happy to go ahead with the scan.
- Staff had a general awareness of Gillick competence in regards to consent for providing care and treatment for children. However, staff told us when children or young adults were scanned in the department, they would usually be accompanied by their parents and a registered children's nurse from the host hospital (for young children). If staff had any concerns about a child and the consent process, they would contact the RMO of the host hospital for advice.

Are outpatients and diagnostic imaging services caring?

Good

We previously did not have the authority to rate this service. However, on this inspection we did have authority to rate and we rated it as **good.**

Compassionate care

- **Staff cared for patients with compassion.** Feedback from patients confirmed that staff treated them well and with kindness. During our inspection, we observed the care and treatment of three patients and engaged with them during their time at the MRI unit. Feedback from patients and their relatives was positive with them commenting on staff's caring and respectful approach.
- We also observed staff interacting with other members of the public who were enquiring about the service and booking procedures. Staff were professional and courteous and tried to ensure conversations were kept as confidential as possible by lowering their voices.
- Staff ensured that patients privacy and dignity was maintained during their time in the facility and MRI scanner. Only one patient was taken through to the scanning area at a time to prevent any dignity issues from arising. Any private conversations were held in the scanning area to prevent any breaches in confidentiality.
- We observed staff introducing themselves to patients and explaining their role during our inspection. This was in line with the recommendations in the National Institute for Health and Care Excellence (NICE) quality standards for patient experiences in healthcare.
- There was a corporate chaperone policy in place which the service complied with. There were posters around the unit with information informing patients of their rights to request a chaperone. We also observed staff informing patients of their rights to a chaperone if they wished. On the day of our inspection, there were both male and female members of staff running the MRI scanning list.

- The service completed the Friends and Family Test (FFT) survey and a general satisfaction survey. This was automatically sent to patients after their scanning procedure. Results showed patients were consistently satisfied and would recommend the service to their friends and family. Information sent prior to the inspection showed the service consistently scored between 98% to 99%, however on the day of our inspection, we saw the most recent results displayed in the unit which showed 100% of patients would recommend the service to their friends and family, with 95% of patients stating they were satisfied or very satisfied with the service provided (the remaining 5% were neither satisfied or dissatisfied). The response rate for the patient feedback was very low and below the expected standard of 20% set by the corporate provider. Information for October 2018 showed the response rate was 11%.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.** Staff told us about times when they had patients where they were required to provide support and comfort after scans due to some significant findings being identified. They told us how it was essential to ensure patients were comforted whilst they arranged for the next steps to be taken and transfer to an acute hospital if required. Thankfully, staff told us this did not occur very often, however in circumstances where patients required support, they would not rush patients through the department and would keep them in the scanning environment where it was confidential.
- Staff told us they were mainly required to provide emotional support to patients with anxiety and claustrophobia concerns. Their support to patients started when patients were referred to the unit for a scan, during the initial telephone call. Staff told us if they sensed when patients were concerned about undergoing a MRI scan (although patients may also tell them directly), they would discuss their concerns on the call and offer them the opportunity to attend the unit and meet the staff and look around the department.
- One staff member told us about an occurrence where they had provided support to a patient who had a complex history, and was convinced they had a significant pathology. However, on this occasion there was no concerns. Staff discussed how important it was at the time to provide this support to the patient and how their communication skills were essential in managing this unique situation.

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.** We found staff taking the time to explain the details of the MRI scan which the patient had attended for as well as staff discussing what the scan included on the telephone. Staff gave patients and any relatives present with them the opportunity to ask questions and clarify points already discussed.
- During the MRI scanning procedure, staff ensured patients were well informed about the progress of the scan, as well as checking they were comfortable through the communication system which was in built.

Are outpatients and diagnostic imaging services responsive?

Good

We previously did not have the authority to rate this service. However, on this inspection we did have authority to rate and we rated it as **good.**

Service delivery to meet the needs of local people

- **The service planned and provided services in a way that met the needs of local people.** The service previously provided a mobile magnetic resonance imaging (MRI) scanning unit at the host hospital. However, this was brought into the building in a purpose-built department in 2014.
- The environment was mainly appropriate for the patients who attended for appointments. Although the unit was not overly spacious, it accommodated the patients attending for appointments as there was only one list running. There was a television and newspapers available for patients whilst they waited as well as hot and cold drinks machines.

- There was a small box of items for young children located within the reception area which contained clean and wipeable items contained within it. However, there were no provisions available for older children who attended the department. Staff did acknowledge the lack of items for older children, however they told us this had not caused any concerns previously as most older children bring their own items to occupy them which they could use in the department.
- There was complimentary wireless internet technology within the MRI unit which staff, patients and visitors could access.
- The host hospital where the MRI unit was located was on main transportation routes and there was adequate free car parking available on site.

Meeting people's individual needs

- **The service took account of patients' individual needs.** There were provisions in place to provide interpretation and translation services to patients whose first language was not English. All staff were aware of how to access this service and have previously had to access this. The reception area also had a hearing loop in place for patients who had hearing difficulties.
- Staff were aware of the individual needs of patients living with dementia and where possible always tried to meet their individual needs. Staff had undergone dementia awareness training to enable them to better understand how best to meet their needs and always encouraged any carers or relatives to stay with the patient whilst they underwent the scan.
- Staff told us they rarely had patients attend the unit who had known learning disabilities. They continued that there were no additional measures which they could put in place if they were made aware of a patient with a learning disability attending for a scan, other than to ensure a carer or relative accompanied them who would be able to go inside the scanning room with them. The service did not have access to a learning disability specialist and staff had not received any additional training in meeting the needs of patient with a learning disability.
- The MRI unit was located on the ground floor of the host hospital and was therefore accessible to all patients including those with disability problems. Within the department, there was an accessible toilet for patients in wheelchairs.
- Staff at the service tried to ensure the needs of children and young people were met when they underwent a scan in the department. Staff would encourage the parents of the child to remain in the scanning room whilst the child underwent the scan, as long as this was safe to do so (parents would also need to complete a risk assessment prior to entering the scanning room). Children were also given story books about characters who went for MRI scans which would explain the procedure to them. After the procedure was complete, children were given a certificate for their bravery.
- The service had basic bariatric provisions in place for patients which included larger chairs in the receptions area as well as manual handling equipment which could accommodate larger weights.
- Staff at the service were aware the main issue which patients often complained about was anxiety related to claustrophobia. To meet the individual needs of these patients, they offered them the opportunity to come and review the scanning equipment prior to their appointment as well as ensuring additional equipment to try and relax the patient was available. Staff would also provide advice on what they could do in preparation for the appointment, including visiting their GP to request medication which would relax them.

Access and flow

- **People could access the service when they needed it.** Waiting times from referral to treatment and arrangements to scan were in line with good practice, and well within agreed timescales with other external providers (both private and NHS). At the time of the inspection, routine referrals were scanned within three weeks maximum, however urgent referrals could be accommodated within days of referral.
- The service currently scanned patients between Monday to Thursday only. Timings during these days were organised to try and meet patient needs. Monday appointments were available from 9am until 7pm and

Good

Diagnostic imaging

Tuesday to Thursday appointments were available from 8am until 6pm. Staff told us there were occasions where patients had requested appointments outside of these times and days, but were understanding when told they did not have appointments for additional days or later times. Staff continued there had been considerations about extending the scanning provision to include Friday's, however there were no confirmed plans for this to go ahead.

- Staff told us there were no issues with prolonged waiting on the day of patient's appointment, however this was not formally monitored. On the day of our inspection, we observed staff informing patients of a 20-minute delay between scans. Staff were open and honest and ensured the patient was comfortable whilst waiting, including offering them a drink. We also observed staff advising patients they would update them further if any further information became available. We did not observe any visual sign to inform patients of the delay in the unit during our inspection.
- There was a process in place to monitor DNA (did not attend) appointments and short notice cancellations. Staff in reception told us they would try contacting patients if they had not turned up for an appointment, if they were unable to make the appointment, they would rearrange another appointment.
- Staff told us there was not an issue with DNA or short notice cancellation appointment at this location. During the period of August 2017 to July 2018, there were 25 (1.3%) patients who either DNA or cancelled their appointment at short notice.
- During the period of August 2017 to July 2018, there were 123 procedures which were cancelled for non-clinical reasons, 17 of which were due to equipment failures. The most common reason for cancellation was at the request of the patient.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.** There was a corporate policy in place for staff to follow, which was dated August 2017. All complaints were expected to be investigated and reported back to the patient within 20 days. If this was likely to be extended due to complexity of the investigation, this was communicated with the patient and updates given regularly.
- There were four complaints raised against the service from August 2017 to July 2018, all of which were upheld by the service. Two of the complaints related to delays in reporting the findings of the scan, one complaint was in relation to the wrong scans being given to a patient for follow up appointments and one complaint was from a consultant at the local acute hospital for not having a robust escalation process in place. All complaints were resolved within the expected time frames.
- Staff told us the complaint about the patient who required escalation had been a significant complaint which had a positive outcome as this prompted staff to review their policy for escalating patients for urgent follow up. This process was now considered to be more robust and staff felt more empowered about escalating concerns.
- For complaints where the host hospital was also included, a joint approach to the complaint investigation was completed and staff would agree between them who would take the lead and therefore respond to the patient involved. None of the complaints received in included the host hospital.

Are outpatients and diagnostic imaging services well-led?

Good

We previously did not have the authority to rate this service. However, on this inspection we did have authority to rate and we rated it as **good.**

Leadership

- **Most managers in the service had the right skills and abilities to run a service providing high-quality sustainable care.** The MRI unit at this location had recently appointed a new unit manager who was on a part-time contract. At the time of our inspection they were still undergoing the induction process and was in the process of applying to the CQC

for registered manager status. They were also working alongside colleagues to understand the clinical processes as they themselves did not have a clinical background, so it was too early to assess them as a leader.

- In the interim period, a manager from another location was supporting the new unit manager one day per week. They had been in a managerial position for a significant period, but also worked clinically as a radiographer. Staff told us they had appreciated the input and support from this manager during this interim period.
- Staff told us they were still in the period of adjustment with the new local management team. However, priorities for ensuring visible and effective leadership were not yet embedded. We did observe an action plan which the new manager had developed which prioritised areas for them to address, and saw evidence of actions already completed.
- Senior staff told us they felt supported by their managers as well as their peers. The corporate provider had recently reintroduced the regional director's management level which had been a positive move, although they had not yet been able to engage with them face-to-face, staff told us they had already felt this provided them more support and had aided escalation procedures as well as improving the cascade of information down.
- Staff spoke positively about the senior executives of the corporate provider. Although they did not see them regularly, they felt they had the right level of support from them and would feel comfortable approaching them if they had concerns.

Vision and strategy

- **The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.**
- The service had implemented the corporate vision and values locally and ensured they complied with this. The values which all staff complied with were centred around collaboration, excellence, efficiency and learning. We observed these values displayed within the department.
- There was no separate local vision or set of values for the service at Leicester Nuffield Alliance MRI Unit. However, staff spoke openly about the willingness to improve the efficiency locally and had started to develop a strategy of how to achieve this, which included plans for extending the scanning availability.

Culture

- **Managers within the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.** However, they were aware that the recent change in management team had impacted on the culture of the service. Senior staff believed this was down to the way the change was communicated prior to the new manager starting in the service.
- Staff had previously gone to the managers of the unit with some concerns including concerns around their own health and well-being, however nothing appeared to have been done about this so this had impacted on their perceptions of the support and approachability of them. Despite this, staff acknowledged if they had concerns about the unit and any risks involving the unit, this would not impact them escalating the concerns.
- Staff told us (and we observed) they worked well as a team and felt supported by their fellow colleagues. There was an acknowledgement of the responsibility that the lead radiographer had and many colleagues told us they liked to try and support them however they could. Staff were also positive about the support they received from colleagues within the host hospital.
- The service had an open and honest culture. Any incidents or complaints raised would have an open and honest 'no blame' approach to the investigation, however in circumstances where errors had been made, apologies would always be offered to the patients and staff would ensure steps were taken to rectify any errors. Staff were aware of the duty of candour regulation; however, they had not had any incidents which met the criteria where formal duty of candour had been required to be implemented.
- There was a process in place to manage staff who poorly performed of whose behaviour was inconsistent with the expected values and standards of the service.

Good

Diagnostic imaging

Governance

- **The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.**
- There was a corporate level clinical governance committee which fed into the integrated governance and risk board meeting. This meeting ensured there was appropriate integrated governance and risk management for the whole service.
- Locally, staff participated in monthly team meetings which had a set agenda and ensured all aspects of governance were discussed. These meetings were minuted and we saw evidence of these minutes during our inspection. Senior staff told us there were clear channels for escalating any concerns or risks from these meetings as well as being the perfect opportunity to cascade important information to the team.
- The service regularly completed a quality score card which was submitted to regional managers and discussed at clinical governance committee meetings. Within these score cards were details of the services performance against access, quality, turn around (of reports), safety and satisfaction.
- There was a radiation protection committee within the organisation, which the medical physics expert attended. Any relevant information from this meeting was fed into the integrated governance and risk board meeting, and the information cascaded down to relevant units, including the service inspected.
- Managers from the service attended regular governance meetings with senior management staff from the host hospital. This ensured there was oversight of the governance which they fed into locally within the hospital as well as enabling them to escalate any relevant local issues to the host hospital senior management staff.
- The provider did not require individual practitioners to hold their own indemnity insurance, all staff working for the service were covered under the providers indemnity insurance. We saw copies of the insurance certificate displayed in all clinical areas.
- Service level agreements and contracts with external providers were managed on a corporate level and not on a local level.
- All staff personnel files were managed by the corporate human resources (HR) staff. Local managers held files on continuous development aspects including appraisals, continuous professional development (CPD), local competencies and training. There was a corporate policy for all staff to follow for disclosure and barring service (DBS) checking. All staff were required to renew their DBS on a three-yearly basis. Although this was overseen by corporate HR staff, the DBS process was completed through an external service.

Managing risks, issues and performance

- **The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- There was a corporate level risk register which all locations fed into. Locally, the service held a register of local risk assessments which were relevant to them. Any risks which were still of significant risk after mitigation was escalated upwards through the recognised governance process.
- During our inspection, we reviewed the local risk assessments and found the risk assessments were detailed and had local ownership. We also observed they were regularly reviewed, with the last review date being just over a month prior to our inspection. All risk assessments reflected the risks we observed and risks which staff spoke about. These included (but not limited to) lone worker scanning, cryogenic gas filling, magnet quenching, manual handling and cardiac arrests.
- The new unit manager developed a local action plan for them to work through on issues which needed addressing within the unit. We observed this action plan during our inspection and saw they had already made progress on this, but still had areas which they were working towards, within their expected time frames.
- Performance was monitored on a local and corporate level using the quality scorecard, annual corporate audit programme, local quality audits and an annual

quality assurance review. Any actions or areas of improvement identified through these methods of monitoring performance required local action plans to be produced. The service had their last annual quality assurance review in May 2018. This identified there were five major non-conformities, nine minor non-conformities and five action points. The service had devised an action plan in response to this audit and had already actioned most of these points, with only two non-conformities left to address. One of these non-conformities was considered a major non-conformity and related to the service not having the most current version of the MRI scanning SOP (standard operating procedure) for children available.

Managing information

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- The service had access to all relevant corporate and local documents through the use of local information technology (IT) infrastructure. Staff were also able to access elements of information securely from their own computers at home, this included electronic mandatory training.
- The service used three separate electronic records systems, each with an individual purpose. Electronic patient records were kept secure to prevent unauthorised access to data however authorised staff demonstrated they could be easily accessed when required. Staff had enough computers to enable them to access them in a timely manner.
- Information about payment and terms and conditions was sent to patients directly, mainly through the use of electronic mailing, although there was the option for standard mailing for patients without an electronic mailing address. Alliance Medical Limited also had a website which patients could visit, which enabled them to search for local scanning places. Contained within this website were copies of the terms and conditions as well as contact details for Leicester Nuffield Alliance MRI Unit.

Engagement

- **The service engaged with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations.**
- Patient satisfaction information forwarded by the service which covered the period of August 2017 to July 2018. The results showed 98% of patients would recommend the service to their friends and family. Staff told us they regularly received positive feedback from patients, however the satisfaction survey was sent automatically following the procedure and the response rate varied from month to month. The most recent results from the satisfaction survey which was sent to patients showed 95% of patients were satisfied or very satisfied, with 5% neither satisfied or dissatisfied. All patients confirmed they would recommend the service to their friends and family, however the response rate was only 11% which was lower than the 20% target set by the corporate provider. The unit manager was aware of the lowered response rate and was considering ways this could be improved.
- Staff from the unit participated in the corporate annual staff satisfaction survey, which was due to imminently be sent out. Senior staff told us they were directly given the results of the satisfaction survey; however, this did not break the results down into locality units to enable managers to get a better understanding of staff satisfaction. However, they did say they hoped staff felt they could directly approach them if they were not satisfied or had concerns.
- Staff were not aware of any well-being or staff supportive systems in place for crisis or ill-health. We were told staff had previously escalated concerns about their health and well-being, however no actions had been taken. We were also told due to staffing levels, there were times when staff were unable to take annual leave and attend training when they had requested, as well as feeling obliged to come into work when feeling unwell.

Learning, continuous improvement and innovation

- **The service was committed to improving services by learning from when things went well or wrong,**

promoting training, research and innovation. However, there was conflicting perceptions from staff about the approach to local service improvement and innovation.

- Senior staff told us the corporate management team were supportive of local staff looking for ways to improve and innovate their local working practices as they appreciated local staff had a better understanding of the processes in their department. However, other staff members felt when they had approached their managers with ideas for improvements, they were not listened to.
- Information received by the service prior to the inspection identified an area of current innovation and improvement which was being looked into was around offering 'one stop clinics' in partnership with the host hospital. This was currently in its infancy and no other staff members referred to this during our onsite inspection.
- One improvement which staff were keen to work on was extending the scanning provision offered at this location. Staff commented this was an area which not only they wanted to improve, but also was an area which the host hospital supported. It was continued that to bring this improvement into the location, this would require an uplift in clinical staff which without exception all staff at this location supported.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The service should ensure all relevant staff have completed paediatric life support training to the level identified in the corporate policy.
- The service should ensure all staff have the opportunity to undertake clinical supervision, continuous professional development and role specific training.
- The service should ensure only staff who have completed appropriate patient manual handling training assist patients in the department.
- The service should consider how they assure themselves the resuscitation equipment is fit for purpose and ready to use in the event of an emergency in the department.
- The service should consider how they encourage staff participation in surveys to understand and drive local improvement in culture.
- The service should consider how they can improve their existing patient engagement to enable them to receive a higher response rate.
- The service should consider how they assure themselves there are no excessive delays to patients on the day of appointments.