

Stockport Imaging Centre

Quality Report

Stockport NHS Foundation trust
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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?

Requires improvement



Overall summary

Stockport Imaging Centre is operated by Alliance Medical Limited. The service provides magnetic resonance diagnostic imaging services to NHS patients throughout the Stockport area and also for private patients. The service sees both adults and children.

Stockport Imaging Centre provides a scan only service. All reporting is completed by radiologists from the host trust. Reports for privately funded patients were completed by a third-party contractor.

The service is based next to the emergency department of the host trust. It was opened in 2002 and contained one scanner at that time. A modular building extension was opened in May 2016 incorporating a second scanner and associated equipment.

The department delivered approximately 14,000 scans in the period June 2018 to May 2019. This figure included 786 paediatric scans and 97 private patient scans.

Summary of findings

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 26 September 2019 and conducted a telephone interview with the unit manager on 4 October 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

Services we rate

We previously inspected the service in 2013 but did not rate it.

We rated the service as **Good** overall for this inspection. This was because:

- Staff received and kept up-to-date with their mandatory training.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff knew about and dealt with any specific risk issues.
- The service had enough staff with the right qualifications, skills, training and experience to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service provided care and treatment based on national guidance and evidence-based practice.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff gave patients and those close to them help, emotional support and advice when they needed it.
- Staff made sure patients and those close to them understood their care and treatment.
- Managers planned and organised services, so they met the changing needs of the local population.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly.
- Staff understood the policy on complaints and knew how to handle them.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action.

Summary of findings

- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.
- Leaders and staff actively and openly engaged with patients and staff.
- All staff were committed to continually learning and improving services.
- Both adult and children safeguarding policies did not reference up to date guidance.
- There was a shortage of administrative staff which appeared to be causing that team additional work pressures. The service had since confirmed that a new staff member had been recruited to the vacant post.
- The administrative environment was cramped.
- The design of the office environment meant it could be difficult for staff to make difficult telephone calls in private if there were also patients in the waiting area.
- The service did not monitor the reasons why patients were not always being scanned in accordance with turnaround time targets, especially cancer patients.

However:

- The service failed to notify us, without delay, of a serious incident requiring notification.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with requirement notices. Details are at the end of the report.

Ann Ford

Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service

Diagnostic imaging

Rating

Good



Summary of each main service

This service provides magnetic resonance diagnostic imaging services mainly for adults and children. The service had enough staff with the right qualifications, skills, training and experience to provide the right care and treatment. The service controlled infection risk well.

Staff followed national guidelines and worked together for the benefit of patients. Staff were caring and always respected the privacy and dignity of patients. Patients did not have to wait long for services. There was a good culture and staff felt respected and valued. There were governance structures in place to support services and manage risk.

However, the service had not notified us, without delay, of a serious incident requiring notification. The service's safeguarding policies also did not reference up to date guidance.

Summary of findings

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Good



Stockport Imaging Centre

Services we looked at

Diagnostic imaging

Summary of this inspection

Background to Stockport Imaging Centre

Stockport Imaging Centre is operated by Alliance Medical Limited. The service opened in July 2002 as a single scanning unit. A second scanner was added in May 2016 following the addition of a modular extension unit. The service provides diagnostic scans to NHS services throughout the Stockport area and also for private patients. The service sees both adults and children.

The regulated activities delivered by this provider are diagnostics and screening.

This location delivered approximately 14,000 scans in the period June 2018 to May 2019.

The service was last inspected in June 2013 but was not rated.

This service has had a registered manager in post since 2011.

The service is accredited by the Imaging Services Accreditation Scheme (now known as the Quality Standard for Imaging). The accreditation scheme was developed by the Royal College of Radiologists and College of Radiographers to support diagnostic imaging services to make continuous improvements to ensure that patients consistently receive high quality services delivered by competent staff working in safe environments.

The service is accredited to ISO27001 standards. This provides a model for establishing, implementing, operating, monitoring, reviewing, maintaining and improving an information security management system.

The service is also an accredited Investors In People employer.

Our inspection team

The team that inspected the service comprised two CQC inspectors and was overseen by Judith Connor, Head of Hospital Inspection.

Information about Stockport Imaging Centre

The service is located next to the emergency department of the host trust and is registered to provide diagnostic and screening procedures. There are 11.2 WTE clinical staff based at this location, and 6.3 WTE administrative staff.

The department consisted of two scanning rooms, a reception and waiting area, two patient changing rooms, a recovery area and an office.

The service is open Monday to Friday 7am to 9pm, and 8am to 8pm at weekends.

Before the inspection we looked at information that the service provided to us. During the inspection, we visited the unit. We spoke with nine staff and observed three scans and patient interactions. We looked at electronic patient records and organisational policies.

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

This location delivered approximately 14,000 scans in the reporting period June 2018 to May 2019.

Track record on safety

- no never events
- one serious incident
- no incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),

Summary of this inspection

- no incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- no incidences of hospital acquired Clostridium difficile (c.diff)
- no incidences of hospital acquired E-Coli
- one formal complaint

Services accredited by a national body:

The service is accredited by the Imaging Services Accreditation Scheme (now known as the Quality Standard for Imaging). The accreditation scheme was developed by the Royal College of Radiologists and College of Radiographers to support diagnostic imaging

services to make continuous improvements to ensure that patients consistently receive high quality services delivered by competent staff working in safe environments.

The service is accredited to ISO27001 standards. This provides a model for establishing, implementing, operating, monitoring, reviewing, maintaining and improving an information security management system.

Services provided under service level agreement:

Service level agreements were agreed with and monitored by Alliance Medical Limited. It was responsible for meeting their parties, agreeing key performance indicators, and negotiating contracts.

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?

We had not rated this service before. We rated it as **Good** because:

Staff received and kept up-to-date with their mandatory training, understood how to protect patients from abuse, and managed safety well. The service had enough staff to care for patients and keep them safe. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.

Good



Are services effective?

We do not rate this domain

The service provided care and treatment based on national guidance and evidence-based practice. Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff monitored the effectiveness of the service and staff worked well together for the benefit of patients.

Are services caring?

We had not rated this service before. We rated it as **Good** because:

Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Good



Are services responsive?

We had not rated this service before. We rated it as **Good** because:

The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Good



Are services well-led?

We had not rated this service before We rated it as **Requires improvement** because:

The service had not notified us, without delay, of a serious incident requiring notification. Its safeguarding policies also did not reference up to date guidance.

Requires improvement



Summary of this inspection

However, leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. The service engaged well with patients and 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 | Requires improvement | Good |
| Overall | Good | N/A | Good | Good | Requires improvement | Good |

Diagnostic imaging

| | |
|------------|--|
| Safe | Good  |
| Effective | |
| Caring | Good  |
| Responsive | Good  |
| Well-led | Requires improvement  |

Are diagnostic imaging services safe?

Good 

We had not rated this service before. We rated it as **good**.

Mandatory training

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

- The service had a comprehensive training schedule setting out what training staff needed and when to complete it. The training schedule was available through Alliance Medical Limited's electronic learning website.
- Mandatory training modules included dementia awareness training, moving and handling, conflict resolution and infection prevention and control, and PREVENT (Preventing radicalisation and extremism).
- Thirty percent of eligible staff had completed paediatric intermediate life support training. However, a further 40% had been booked on training to be completed by the end of October 2019, and all staff had paediatric basic life support training. In addition, staff had access to the trust's paediatric ward staff and crash team.
- Training records were stored electronically. The system alerted staffed within 60 days and 30 days of expiry of any training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

- All staff had received adult and children safeguarding training at the appropriate level (level one or two).
- The service had a safeguarding lead who had been trained to level three. They also had access to the host trust's safeguarding team (as well as the trust's safeguarding system) and a paediatric lead radiographer. The service had planned to train two further staff to children safeguarding level three but were awaiting training dates to become available.
- The staff we spoke with could articulate what a safeguarding concern was and how they would report it. Some staff gave us examples of when they had reported concerns.
- Pathways for making safeguarding referrals were displayed throughout the unit, including the waiting areas and in the control rooms.
- However, the service's safeguarding policies, both children and adults, did not reference up to date guidance; Intercollegiate documents - Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition: January 2019; or Safeguarding: Roles and Competencies for Health Care Staff First edition: August 2018.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Diagnostic imaging

- The service displayed posters reminding staff about the “5 Moments for Hand Hygiene” approach which defines the key moments when healthcare workers should perform hand hygiene.
- There were hand gel dispensers throughout the department. The patient changing area included a sink and hand soap for patients to wash their hands.
- We saw staff using hand gel and wearing personal protective equipment.
- There was a list of cleaning duties to be undertaken each day and week. We reviewed the log book for the previous month and saw that this was up to date. This included mopping floors and cleaning parts of the scanning machines with appropriate wipes.
- The service conducted monthly infection prevention control audits. The data for August 2019 showed that the service was compliant in 19 of 20 areas. These included a clean and tidy environment, hand hygiene and availability of spill kits. The service was not compliant with the availability of certain wipes, but this was due to a change in supplier and the new stock not being delivered. This had been resolved at the time of inspection.
- If the service was due to scan an infectious patient, it could liaise with the host trust’s infection prevention and control team, if necessary, for advice about correct decontamination protocols.
- Patient changing areas included lockers for patients to store personal items during scans.
- Each scan room contained an emergency buzzer for patients to use. We saw that these were working.
- There were sharp bins near to the control room. These had been appropriately dated and signed and were not above their fill line.
- We saw that cleaning fluids were kept in locked cupboards.
- Equipment had been appropriately safety tested.
- The parent company arranged for the servicing of equipment via a planned preventative maintenance programme. There were set schedules for the scanners to be serviced (either twice or four times a year depending on the machine). The service could also request any urgent repairs should it be necessary outside of the maintenance schedule.
- The service had an up to date and site specific business continuity plan, with contact numbers and pathways to follow. We saw evidence of the plan being tested.
- There was a first aid kit easily accessible for staff. The nearest defibrillator was well signposted.
- There was a water cooler in the waiting area that patients could use whilst they were waiting.
- There was a staff restroom which included tables, chairs, microwave, toaster, kettle, fridge and television.
- However, whilst the environment was safe, certain parts of the department were cramped and there was little space in the office for administration staff.
- The way the reception desk was set up meant that it was difficult for staff to have private conversations with patients on the telephone when there were patients in the waiting area.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

- The service had access to the host trust’s resuscitation trolley. The host trust was responsible for ensuring that the trolley was stocked correctly. The service carried out a daily check to ensure that the trolley was in the correct location (it was stored in the neighbouring department and was easily accessible).
- Equipment was appropriately labelled to say whether it was “MR safe”, “MR unsafe” or “MR conditional”. This was in accordance with The Medicines and Healthcare products Regulatory Agency Safety Guidelines for Magnetic Resonance Imaging Equipment in Clinical Use (March 2015).

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

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- Referrals could be made by GPs or by consultants at the host trust. Referrals received by the unit highlighted whether patients had allergies to contrast agents.
- The service had a clear Management of Medical Emergencies policy. This included detailed information about how to recognise a deteriorating patient, and the emergency response process. The Paediatric Referral Management policy set out the specific actions staff should take to manage paediatric emergencies.
- The Paediatric Referral Management policy also set out how to manage paediatric patients safely. This included children under the age of 13 being cannulated by paediatric clinicians from the trust.
- The service had leaflets for patients detailing what signs and symptoms to look out for after they had been given a contrast agent. This included swelling and tenderness. Patients were given advice about how to manage the symptoms, and what to do should they get worse – including contacting the trust’s scanning department. The leaflet also informed patients that the host trust would contact patients that had been given contrast agents 24 hours after leaving hospital.
- There was appropriate signage throughout the department regarding the risk of magnets. Signage was prominent on the floors and doors leading to the two scanning rooms. Signage was in accordance with The Medicines and Healthcare products Regulatory Agency Safety Guidelines for Magnetic Resonance Imaging Equipment in Clinical Use (March 2015).
- The service followed the Society of Radiographers Pause and Check checklist. This was a six stage checklist used to ensure, amongst other things, that the correct patient and body part was scanned, that the two way intercom was working, patients were weighed, and confirmation of image quality.
- There were a number of pathways displayed in the control room area relating to the deterioration and collapse of a patient. These included the management of cardiac arrest in the control room. There were also numerous Resuscitation Council Guidelines (2015) displayed in the control room area regarding advanced and basic life support, and in-hospital resuscitation.
- The service acted in accordance with the Resuscitation Council Guidelines “ABCDE” approach to managing deteriorating or critically ill patients.
- The service had a safe staffing policy. This set out that there should be a minimum of two qualified staff in the management of medical emergencies and recognition of deteriorating patients.
- Posters were displayed within the service asking patients to tell staff if they thought they could be pregnant.
- Urgent patients, such as those on the two week cancer pathway, were clearly flagged. Scan slots were reserved daily for such patients.
- All patients completed a “patient safety consent form”. This confirmed their name, date of birth, weight and height. There were checks about whether patients had certain types of implants that could be dangerous in the magnetic resonance scanner - pacemakers, cochlear implants or metal surgical clips. Patients were asked whether they are, or could be pregnant, and whether they suffered from conditions such as epilepsy or asthma. The safety consent form informed patients that they will be asked to remove any metal items from their body, including prosthetic limbs.
- The “patient safety consent form” contained a final checklist for staff to ensure that they had asked all relevant safety questions.
- The service carried out monthly patient data checks to ensure staff were checking that the right patients had attended for scans. A sample of records were audited to ensure patients’ names, dates of birth and addresses had been recorded and checked by staff. Data from September 2019 showed that staff were adhering to the checklist.
- Reception staff used a script when booking appointments for patients. They asked questions about (amongst other things) whether patients had a pacemaker, surgery to the head or heart, surgery in the last three months, or implanted devices. If the patient answered yes to any of the questions, they were advised that it was unlikely they could have a scan. There were similar safety questions for those patients requiring contrast agents, including whether they had any renal impairment or were diabetic.

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- We observed reception and clinical staff asking patients the safety questions.
- Reception staff had a checklist for what other information needed to be sent with patient appointment letters. These included specific information leaflets, and for paediatric patients, sedation information and an accompanying person form.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to provide the right care and treatment. Managers reviewed staffing levels and skill mix and gave bank staff a full induction.

- The service occasionally used bank staff (20 shifts had been filled by bank radiographers in the previous three months) and ensured that they completed a local induction. They were also expected to complete mandatory training modules as per permanent staff. This includes basic and intermediate life support training as required for their role. Bank staff were asked to provide evidence to demonstrate prior experience.
- The service told us that agency staff had not been used for several years. However, it told us that agency staff would be expected to complete training as per bank staff.
- Most staff had had an appraisal in the previous 12 months.
- The service operated apprenticeships for healthcare assistants.
- There were low vacancies rates at the service (two positions) and low sickness rates (less than 6%).
- The service had a radiographer staffing calculation tool to help determine the number of staff needed for various shift patterns.
- The three available administrative staff told us that they were extremely busy due to being two staff short (due to sickness absence and another leaving the company). They told us that they needed three members for the office to work smoothly, and this

made it difficult when one of them was on leave, for example. However, they told us that they worked well as a team and had additional support from a healthcare assistant.

- The unit manager acknowledged the staffing issues within the administrative team and explained that they were currently interviewing for a new member of staff. However, the service told us that administrator hours were higher than the staffing calculator recommendation prior to recruitment.
- The service's Staffing Requirements in Support of a Safe Scanning Pathway stated that "at no time must staff be alone in any unit with patients at either the beginning or end of the working day".

Records

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

- The service used a computerised radiology information system (CRIS) to manage patient information and store patient records. Images and reports can also be printed from this system and sent to the referring clinician.
- Scans could be easily shared with other departments in the hospital using the picture archiving and communication system (PACS).
- Reports were sent to the patient's doctor or clinician that referred them for the scan. Patients were advised that the referring clinician would contact them with the results within six weeks.
- Paper referral forms were disposed of in the confidential waste once they had been entered onto the electronic system. They were kept in a locked cabinet in the office (accessed by a key coded door) whilst waiting to be entered on the system. Confidential waste was collected by a third party contractor.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

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- The service stored contrast media and medicines such as buscopan and sodium chloride. The medicines were stored in two locked metal cupboards and the keys were also stored securely.
- The service stored emergency medicines safely and these were restocked by the host trust's pharmacy team every six months (or as required).
- The service had kept a daily log of what medicines had been used each day. We checked and saw that they had been reconciled correctly.
- The service had access to Alliance Medical Limited's pharmacy advisor if required.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

- Incidents were reported on an electronic system. The service had access to the host trust's separate system and reported incidents on this if they involved the trust. These incidents were also dual reported onto Alliance Medicals own incident reporting system. The service told us that feedback from all incidents were discussed in team meetings.
- The incident reporting pathway was displayed in the front office.
- The service could describe how it responded to a serious incident, including calling the trust emergency response team via a dedicated number.
- Incidents and any learning were shared with staff during team meetings. Incidents were also shared nationally via the "Risky Business" newsletter. We saw that the newsletter contained details of the serious incident, highlighting what staff had done well, and any lessons learned. We also saw that the serious incident was discussed during an Alliance Medical Limited's monthly clinical governance committee meeting.

- Staff we spoke with could describe what Duty of Candour was.

Are diagnostic imaging services effective?

We do not rate this domain

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

- Alliance Medical Limited used accreditation schemes to ensure best practice against industry standards. The service was accredited by the Imaging Services Accreditation Scheme (now known as the Quality Standard for Imaging).
- As the service provided scanning for stroke patients, it worked closely with the host trust to ensure that the joint services they provided were in line with national guidelines. The trust developed local guidelines, in conjunction with the service, to meet national guidelines.
- Alliance Medical Limited had developed a Quality Management Framework policy. This set out how audits would be used to monitor the effectiveness of a service. It stated that screening services would only be offered that were in line with national screening practices.
- The service had a comprehensive audit schedule that set out the type of audit and how often it would be carried out. Audits included, amongst others, infection prevention and control, image quality, information governance, and referral to scan times.
- The service produced an annual infection prevention and control report. There were no concerns about the unit.
- The service had developed its own "MRI Local Rules" policy. The policy aimed to "provide the overarching operational safety controls for MRI safety" at the unit. The policy contained details such as the magnetic resonance responsible person, and specific safety

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details about each scanner. The policy also highlighted a list of equipment that was classified as “MR safe”, “MR conditional”, or “MR unsafe”, and fire safety procedures.

- New guidance, and any updates to policies, were discussed and signed off at Alliance Medical Limited’s monthly clinical governance committee. Updated policies were displayed in the home page of the service’s intranet.
- All policies and guidance were kept on a shared drive that all staff had access to.

Pain relief

- We observed staff asking patients whether they were in pain.
- Staff told us that they used different techniques for spinal patients to help reduce the number of scans needed and the time spent on the scanner to reduce pain.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

- The service was accredited by the Imaging Services Accreditation Scheme (now known as the Quality Standard for Imaging).
- There was an internal audit schedule for the service. Audits included infection control, mandatory training, health and safety, equipment and servicing, customer satisfaction, staff survey, risk assessment, document control, training and staff rota.
- Audit results were fed back to staff during team meeting. Certain results, including turnaround times and infection prevention and control audits were also displayed within the unit.
- The service had a planned roll out of image audits beginning at the start of October 2019. Alliance Medical Limited had created a portal for all of its locations to

upload ten scans. Alliance Medical Limited planned to produce a report at the end of each month to highlight areas of good practice, and any areas for improvements and lessons learnt.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

- The service had a comprehensive training schedule for staff.
- Each member of staff had to be signed off for each modality on each scanning machine. Competencies were tested on a yearly basis and we saw that these were up to date.
- Competencies included training on the pressure injector; how to draw contrast and how to check for air bubbles, for example.
- New starters had a comprehensive training programme which lasted six months. Staff had to be signed off for each competency. They were assigned a mentor who helped guide their progress. There were also regular meetings with a nominated assessor during the six month probation. We reviewed one training file and saw that the member of staff had received regular reviews and assessments during their initial induction.
- Induction training included mandatory training modules such as intermediate life support, and patient confidentiality.
- All members of staff had ongoing support from the service’s clinical lead.
- The service displayed details of the Magnetic Resonance Protection Supervisor, and the Magnetic Resonance Protection Advisor.

Seven-day services

- The service was open Monday to Friday 7am to 9pm, and 8am to 8pm at weekends.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed

Diagnostic imaging

national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

- Mental Capacity Act training was included as part of mandatory training.
- We observed staff checking that patients were happy to proceed with scans and for other interventions, such as injecting contrast agent
- Staff we spoke with understand their roles and responsibilities under the Mental Capacity Act. Staff could also clearly explain Gillick competence (the right of a child under the age of 16 to consent for treatment without parental involvement) which was important as the scanned children under the age of 16.
- All patients (or parents/guardians) were asked to sign a patient safety consent form confirming that the risks and benefits of the scan had been explained.
- Staff told us that if they had concerns that a patient lacked capacity to consent for the scan, they would not proceed and would speak to the referring clinician.

Are diagnostic imaging services caring?

Good 

We have not rated this service before. We rated it as **good**.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

- We observed administrative and clinical staff interacting with patients. They were kind, compassionate and helpful.
- We observed a number of staff working to move a patient with back pain. They took their time with the patient and fully explained what they were doing and checked whether the patient was in pain.
- We spoke with one patient who told us that staff had given them enough information to understand what would happen during the scan.

- Further staff interactions included checking that the patient was comfortable.
- There were individual patient areas where they could get changed into a hospital gown in privacy and with dignity.
- The service could arrange chaperones for any patients if required (there were signs in the waiting area about chaperones).
- The service monitored friends and family test scores and discussed these during monthly governance meetings. 90% of patients said they would recommend the service to family and friends.
- The service had a Privacy, Dignity and Respect policy. This set out the attitudes and behaviours expected of staff, how to best communicate with patients, including introducing themselves via the "Hello, my name is ..." campaign. The policy referenced the Care Quality Commission's regulation about dignity and respect.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

- We observed staff regularly checking with a patient via an intercom during the scan. They warned the patient about upcoming loud noises they would experience during the course of the scan.
- Patients were given the option of listening to the radio (via headphones) during the scan to help block some of the noise. Ear protectors were also available for all patients to help block the noise.
- We observed staff explaining to patients how they would feel after being given a contrast agent and checking that they were happy to proceed.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

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- The appointments were long enough for patients to ask any questions. We observed two scans and staff took their time and answered any questions the patients had. Patients were not rushed by staff and there was enough time for each patient appointment.
- One patient told us that staff had liaised with their family to help arrange the appointment. We also witnessed a radiographer explaining the reporting process to the patient and their family.
- There were chairs outside of the magnetic resonance scanning room for relatives to sit during patient scans.

Are diagnostic imaging services responsive?

Good 

We have not rated this service before. We rated it as **good**.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

- There were two scan rooms, a waiting area, an office and two patient changing rooms within the unit.
- The service was open for 14 hours a day during weekdays, and 12 hours a day at weekends to help patients attend at times that suited them. Patient feedback showed that 90% of patients were satisfied with the date and time of their appointments.
- Referrals could be made to the department by GPs and consultants. These could be electronic requests or paper referrals.
- The waiting room had enough seating for patients. There was also an area where in-patients arriving on hospital beds could wait.
- Staff had training on moving and handling which was part of mandatory training. They could also request

help from trust staff if a patient needed to be moved by a hoist (the service did not have staff trained in the use of a hoist). The service had patient transfer guidance.

- Appointment letters were sent to patients. These contained information leaflets relating to the type of scan they would be having and contained details of any preparation they needed to undertake before attending
- The service was accessible by public transport. Patients were sent a site map containing details of how to get to the service by car, train or bus – and where the unit was within the hospital.
- The service had weekly and quarterly meetings with the host trust to discuss the unit's performance, and how it was meeting the needs of NHS patients at the trust.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

- There was a child specific management pathway that aimed to ensure the needs of children were met. For example, the service aimed to ensure that children did not have to wait for their scan. Toys were also available if necessary.
- On the day of the inspection, the service displayed a poster informing patients that all staff working that day were the same sex and to let reception know if they were not happy for the scan to proceed.
- The scanning machines were suitable for most bariatric patients, with a weight capacity of 200kg.
- The service was wheelchair accessible. Patient trolleys could also be manoeuvred in the department.
- The service could provide translators, including British Sign Language, for those patients that required them.
- The service had a hearing loop for patients and visitors with hearing impairments.

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- Large font documents could be printed for visually impaired patients if required. Patients with guide dogs could also be accommodated.
- Staff told us that appointments could be made for patients who were anxious to view the scanner prior to their appointment.
- The service had liaised with GPs about anxious patients to prescribe medication to keep them calm during the scan.
- There were visual guides to help prepare patients with learning difficulties or autism to prepare for their scan.
- The service had a number of patient information leaflets. However, there was no information on these advising whether patients could request the information in a different language.
- The service had access to the host trust's dementia champion who had also delivered training to staff.
- The service had a set of "periscope" glasses that patients could wear in the scanner if they wanted to see out.
- The service worked closely with the trust's paediatric department. Staff would be given notice of any babies that needed scanning and would allocate slots to coincide with their feed and sleep.
- When making appointments, the administration staff would ask whether a patient had any clinical issues staff would need to be aware of, including autism or dementia.
- Whilst the service did not arrange patient transport, it did liaise with ambulance crews should a patient be brought to the unit by ambulance.
- The service had turnaround targets to meet relating to the time taken from receiving a referral to scanning a patient – six weeks for routine patients, 14 days for urgent patients and six days for cancer patients.
- We saw turnaround time data for the seven months prior to the inspection. This showed an improving figure for routine patients from 17 days (March 2019) to 11 days (September 2019).
- The service provided a breakdown of the turnaround time figures for routine (90%), urgent (69%) and cancer patients (27%). The service acknowledged that the figures for urgent and cancer patients were low, but provided context. For example, consultants would often plan patients to have scans at a certain date (after chemotherapy), or there would be other clinical justifications or patient choice. The service explained that the monitoring of this data was not sophisticated enough to capture the reasons why a turnaround time target was not met. However, the service explained that this was why there were weekly meetings with the trust to discuss performance and address concerns or data anomalies.
- The service operated a stroke clinic with dedicated slots for stroke patients, including at weekends. Consultants at the host trust could book patients into these protected slots.
- The service had recently started a spinal clinic which also had dedicated slots, including at weekends.
- The service's "did not attend" rates were 5.4%. It aimed to improve these by ensuring reception staff contacted all patients, that had not confirmed their appointment, 24 hours in advance to check they were attending. Patients were also given email and text reminders. Patients that did not attend for their appointment were given two further chances to attend at which point they would be passed back to the referrer.
- The "did not attend" process was different for patients on the cancer pathway. Patients with suspected cancer were not removed from the list and were given further opportunities to attend, along with the referrer being informed. This applied for those patients with a known health condition, such as dementia, that might affect their memory.

Access and flow

People could access the service when they needed it and received the right care promptly.

- Stockport Imaging Centre provided a scan only service. The host trust completed all reports for NHS patients. The service had a service level agreement with a third party provider to provide reports for private patients.
- The "did not attend" process was different for patients on the cancer pathway. Patients with suspected cancer were not removed from the list and were given further opportunities to attend, along with the referrer being informed. This applied for those patients with a known health condition, such as dementia, that might affect their memory.

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- The service had tried to improve the “did not attend” rates by working closely with a project manager from Alliance Medical Limited. However, after reviewing patient data, it was not clear where improvements to its process could be made.
- The service had not cancelled any appointments in the previous 12 months.
- The service had 252 delayed appointments in the previous 12 months, approximately 1.8% of all appointments.
- If a scanner was out of service, the service could bring in a mobile scanning unit to ensure continued patient flow. The process for requesting this was detailed in the services business continuity plan.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

- The service displayed leaflets in the waiting areas informing patients how they could complain. It set the different stages of the complaints process, and what support they could get via the host trust’s patient advice and liaison service.
- The service’s complaints policy included details of the final adjudication service for NHS patients (Parliamentary and Health Service Ombudsman) and for private patients (the Independent Sector Complaints Adjudication Service).
- The service had one formal complaint in the 12 months to May 2019. This was not upheld.

Are diagnostic imaging services well-led?

Requires improvement 

We have not rated this service before. We rated it as **requires improvement**.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

- There was a clear management structure in place at the service with clear roles and defined responsibilities.
- Managers were aware of the challenges facing the unit, including contract negotiations with the host trust, staffing issues with the administrative team, and the layout of the office environment.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. It aimed to provide high standards of diagnostic imaging to meet the needs of the commissioners, referrers and their patients.

- Alliance Medical Limited had an overall vision, values and strategy for all of its sites. Its vision and values included collaboration, excellence, learning and efficiency.
- The service displayed the vision of the service within its front office.
- The service’s visions and values formed part of staff personal development reviews.
- The service was entering a contract negotiation phase with the host trust.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

- There was a positive culture at the service and staff appeared to enjoy their work. One member of staff told us that they received “fantastic” support from the managers. We saw two thank you cards from staff that had left, one which thanked the team for having made them feel welcome.
- There were low levels of staff vacancies and sickness.
- Staff told us that communication with Alliance Medical Limited had improved over the last four years and was

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much better. They told us that parent company listened to their views and changes had been made to processes (including the patient safety consent form) as a result.

- Alliance Medical Limited's Quality Management Framework policy stated that the service did not discriminate against people with protected characteristics. In addition, there was an organisation wide "Code of Conduct" setting out how staff should act with colleagues and patients.
- Staff development was discussed at the unit managers meeting in July 2019. This included discussions around the benefits of the personal development review, and training and development opportunities.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

- There was a clear governance structure at the service. This provided clear routes to escalate information to the quality and risk managers for children and adult services, and to the director of quality and risk.
- There was a clear process to ensure that information at service level was reviewed by Alliance Medical Limited. This was set out in the Governance Framework – Committee Structure which detailed how often committees and governance groups would meet.
- There were planned bi-monthly meetings, due to start in December 2019, with directorate managers and finance team from Alliance Medical to discuss contracts and financial performance.
- There were monthly team meetings at the service and we saw the minutes for these. There was a standard meeting agenda that included discussions about regulation and accreditation, mandatory training, incidents, complaints and compliments and the "did not attend" project. Actions were assigned to various staff members and staff groups with a defined timescale for completion.

- There was a monthly regional unit manager meeting where sites could discuss such things as recruitment and human resources issues, training needs, business development and safety issues, incidents and share best practice. Actions were discussed and assigned to relevant managers. There was also a brief weekly call between the same unit managers to allow the ability to discuss any high level issues.
- Policies were managed by Alliance Medical Limited and were available on the intranet for individual services to review. Policies due for approval or ratification were discussed during Alliance Medical Limited's monthly clinical governance committee meetings.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

- Alliance Medical Limited had a Quality Management Framework policy. This set out how its services would "strive for continuous improvement ... and become a learning organisation". The purpose of the policy was to "ensure diagnostic imaging services meet high standards of clinical quality and patient safety".
- The policy set out a clinical structure for clinical leadership and accountability throughout the entire Alliance Medical Limited group. It also set out how risks should be managed through local risk assessment and risk registers. These were underpinned by various audits including image quality audits (which were starting to take place). There was a comprehensive audit schedule in place.
- The service met weekly with the trust to discuss such things as patient pathways, turnaround times or any data anomalies.
- There were also quarterly quality meetings with the trust's clinicians involving all the radiologists and the radiology manager. The service told us that there was a good working relationship with the trust and they felt able to question and challenge where necessary.
- The service had its own local risk register. This contained a description of the risk, the controls

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currently in place, the current risk score and the target risk score. The highest risk related to staff stress and absence, followed by the hazardous magnetic resonance environment.

- The local risk register was managed by the unit manager. It was discussed with the Alliance Medical Limited governance team who attended the site every six months to discuss any ongoing or new risks. A report would be produced which would be discussed at Alliance Medical Limited board meetings.
- The service confirmed that they could contact the governance team outside of the scheduled meetings. The unit manager could also discuss the service's performance, and any risks, during a weekly call with their line manager.
- Any Medicines and Healthcare Products Regulatory Agency alerts were sent to the parent company and then cascaded to the unit manager to act on.

Managing information

Data or notifications were not consistently submitted to external organisations as required. However, the service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

- The unit had not reported a serious incident to us as they were legally obligated to.
- We spoke to the service about this during our investigation. It told us that it had been working with the host trust to review policies and processes regarding the notification of such incidents. These policies had not been signed off by the trust. The unit manager confirmed to us that they would immediately report all such incidents to us in the future should they recur.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

- All policies were stored online and could be easily accessed.
- Alliance Medical Limited was responsible for reviewing and updating any policies. Any that had been updated where displayed on the intranet home screen.
- There was a specific Stockport Imaging Centre homepage on the intranet. This referenced site specific documentation such as the business continuity plan.
- Computer systems were password protected. We observed staff locking their computers when they moved away from their desks.
- The service was accredited to ISO27001 standards. This provides a model for establishing, implementing, operating, monitoring, reviewing, maintaining and improving an information security management system.
- The service had a clear records management policy included details of the retention and disposal schedule for records. Whilst this referenced the Data Protection Act 1998 and the Freedom of Information Act (2000), there was no reference to the General Data Protection Regulation (2016).

Engagement

Leaders and staff actively and openly engaged with patients and staff. They collaborated with partner organisations to help improve services for patients.

- The service displayed posters in the patient changing areas asking for feedback about the scan and the staff. Patients were asked to complete a form that had been emailed to them.
- The service had introduced a Star of the Month which it announced in each team meeting.
- The service worked closely with the host trust to ensure that they acted in accordance with guidelines, and to discuss complex patients. Staff told us that there was a good relationship with the trust.
- Alliance Medical Limited carried out yearly staff surveys and produced plans to improve staff engagement. Following the last survey, Alliance

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Medical Limited introduced various ways try and make staff feel more valued. This included various recognition schemes. The data could not be broken down to individual location level.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

- The service is working with a local specialist trust to improve the image quality of prostate scanning.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure that all incidents requiring notification are sent to the Care Quality Commission without delay.

Action the provider **SHOULD** take to improve

We found areas of improvement in this service:

- The provider should ensure that its policies reference up to date guidelines.
- The provider should continue to monitor the staffing levels within the administrative team to ensure there is sufficient cover.
- The provider should review where staff can make sensitive telephone calls to patients to ensure privacy and dignity is maintained.
- The provider should review how it can monitor the reasons why it was not always meeting the turnaround time for patients, to enable it to improve performance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

| Regulated activity | Regulation |
|-------------------------------------|--|
| Diagnostic and screening procedures | <p>Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services</p> <p>The service failed to notify us, without delay, of a serious incident requiring notification.</p> |