

Aston University Consulting Limited

# Aston Institute of Health & Neurodevelopment

## Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

### Ratings

#### Overall rating for this location

Good



Are services safe?

Good



Are services effective?

Inspected but not rated



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good





# Summary of findings

## Overall summary

We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients. Key services were available to suit patients' needs.
- 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.
- 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.
- 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. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and all staff were committed to improving services continually.

However:

- We found that consent forms were not always consistently completed, and they were not audited.
- The records management policy was 4 years out of date and lacked key information and up to date national guidance.
- There was no strategy or business continuity plan for the service.



# Summary of findings

## Our judgements about each of the main services

### Service

#### Diagnostic imaging

### Rating

Good



### Summary of each main service

We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients. Key services were available to suit patients' needs.
- 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.
- 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.
- 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. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and all staff were committed to improving services continually.

However:

- We found that consent forms were not consistently completed and they were not audited.
- Managers did not have processes in place to check on staff's performance in their other workplaces.



# Summary of findings

- The records management policy was 4 years out of date and lacked key information and up to date national guidance.
  - There was no strategy or business continuity plan for the service.
-



# Summary of findings

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# Summary of this inspection

## Background to Aston Institute of Health & Neurodevelopment

Aston Institute of Health and Neurodevelopment provides diagnostic MRI imaging and Clinical Neurophysiology services to adults, and children between the ages of 4 and 18 years. It is an independent scanning service located on the Aston University campus. Children and adult patients attending for MRI and MEG diagnostics will do so only as tertiary referrals e.g. as specialist referrals following requests for investigations by a consultant clinician in an NHS Trust or in the private sector. The service will accept GP referrals for neurophysiological diagnostics for adults and children.

The service was open on Monday to Wednesdays between 9am and 5pm for clinical patients and Thursdays and Fridays for research only.

The service had 2 registered managers who managed the service together.

## How we carried out this inspection

We carried out this announced inspection using our comprehensive inspection methodology on 26 June 2023. The inspection team consisted of an inspector and a specialist advisor with expertise in diagnostic scanning with oversight of an operations manager. During the inspection visit, the team:

- Spoke with 2 patients and their families
- Spoke with 7 members of staff
- Looked at 5 sets of notes
- Looked at a range of policies, procedures, audit reports and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

## Outstanding practice

We found the following outstanding practice:

- The service found that children did not always feel comfortable removing their glasses for their MRI scans as this meant they were not able to watch a video to help them through the scan. They had therefore sourced safe, non-metal glasses with a range of different prescriptions for them to wear whilst in the scanners.
- They allowed children to bring a soft toy with them, following a check of MRI safety. Staff asked the child the name of the soft toy so that they could involve it in the care with the child.
- Staff had created a storyboard for an autistic child prior to their scan to ensure they were well informed and knew what to expect.

## Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a service **SHOULD** take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.



# Summary of this inspection

## Action the service **SHOULD** take to improve:

- The service should ensure that their policies are up to date including the Data Protection Policy (Regulation 12 Safe Care and Treatment).
- The service should ensure that consent forms are fully completed for all patients and the documentation is audited (Regulation 17 Good Governance).
- The service should consider checking the competence of their staff within their other workplaces.
- The service should continue to complete quality audits of their images.
- The service should consider auditing the patient records.
- The service should consider implementing a strategy for the service.
- The service should consider implementing a business continuity plan.



# Our findings






## Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Inspected but not rated	Good	Good	Good	Good
Overall	Good	Inspected but not rated	Good	Good	Good	Good



# Diagnostic imaging

Safe	Good 
Effective	Inspected but not rated 
Caring	Good 
Responsive	Good 
Well-led	Good 

## Is the service safe?

Good 

We rated safe as good.

## Mandatory training

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

Staff received and kept up-to-date with their mandatory training. Staff were notified by the registered manager, who kept a training matrix, when they needed to refresh mandatory training and told us they were given time to complete it.

At the time of our inspection, the mandatory training compliance for clinical staff was 86%. The non-clinical staff had a compliance of 95.83%; this gave an overall training compliance of 90.91%. The service did not have a target for compliance.

The mandatory training was comprehensive and met the needs of patients and staff. It included modules such as fire safety, infection control, safeguarding and health and safety. There were additional training requirements for some staff depending on their role within the organisation. Mandatory training was completed electronically. Staff were not allowed to work within the building if they had not completed certain mandatory training modules such as safeguarding level 1 training.

Staff also completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia; 71% of clinical staff had completed autism training. The learning disabilities module had recently been released and staff were starting to complete this. We saw that 29% of staff had completed it.

## 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.**

Staff received training specific for their role on how to recognise and report abuse. The service had safeguarding processes and procedures in place. These were in line with the local children's hospital, in which they had links with the



# Diagnostic imaging

safeguarding team. They also had a separate safeguarding policy from the University. The clinical staff were trained to safeguarding level 3 for both vulnerable adults and children. All other staff members were trained to safeguarding level 1 for adults and children. Training compliance was 100% for all safeguarding training. Staff initially completed safeguarding training during induction and undertook refresher training annually.

Staff followed safe procedures for children visiting the service. There was a comprehensive policy which clearly outlined the provider's responsibility for ensuring children were safe at the clinic. There was also a consent policy which included steps for clinicians to take when discussing the treatment and gaining consent; all children were accompanied by an adult.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They had not had to raise a safeguarding concern but were able to explain what would trigger a safeguarding concern. The policy clearly outlined types of abuse and the process for staff to follow should they have any concerns. They also had close links with the neighbouring children's hospital safeguarding team and had a direct contact if further support was required.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with were able to tell us signs of different types of abuse, and the types of concerns they would report or escalate to the safeguarding lead. All staff knew who the safeguarding lead was. The safeguarding policy clearly outlined the name and contact details for the safeguarding lead for staff to contact. They also included the contact details for the local safeguarding boards and a flowchart on the action staff should take.

The service did not have a chaperone policy; however, all scans took place with 2 members of staff always present, one of which was always female, therefore the service did not feel that this was required.

## 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.**

Clinical areas were very clean and had suitable furnishings which were clean and well-maintained. Guidance was available for staff in the form of an infection prevention and control (IPC) policy. The policy detailed all protocols required to maintain a good level of cleanliness, infection control and hygiene. There was an infection prevention and control assurance framework, however, it kept referring to the 'trust' rather than the service itself. There were elements of the framework which were not relevant to the provider.

The service had an external cleaner who attended daily to clean the main areas; they had received basic magnetic resonance imaging (MRI) training to ensure they were aware of the risks of the scanner and not to clean this room. Staff cleaned work surfaces, floors and changed mop heads daily, other areas were cleaned on a weekly basis. Records showed that these were completed. Staff used appropriate wipes to clean equipment, including wipes which did not cause the equipment to perish. They used 'I am clean' stickers on equipment to show that they had been cleaned.

There was a spill kit, which was in date, available for body fluid spillages; this would be rare as they did not perform any invasive investigations at this service.



# Diagnostic imaging

Staff followed infection control principles including the use of personal protective equipment (PPE). There were handwashing basins available in all clinical spaces and plenty of alcohol hand gel throughout the clinic. There were posters on how to wash your hands effectively displayed in the toilets and above the sinks in clinical areas. This guidance was in line with national best practice guidelines.

They had a service level agreement with a local NHS hospital IPC team. They completed an annual IPC audit; this was completed in July 2022 and was 96%. There was an associated action plan which had been mostly completed with an outstanding action chased in June 2023. We were told that all audits were discussed in the clinical governance meetings. The IPC team offered guidance and assisted with policies and procedures when required. They also attended clinical governance meetings with the provider.

The service performed well for cleanliness. They completed an annual audit programme. This included hand hygiene audits and environment audits. The hand hygiene audit was completed using an ultra-violet glow box; September 2022 results were 100%.

All clinical staff had completed level 1 and 2 IPC training, and 1 radiographer had completed level 3 training. Training compliance for level 1 IPC was 86% and level 2 was 71%. Non-clinical staff were 100% compliant for level 1 IPC training. We were not told if there was a plan to improve the compliance.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff documented cleaning of equipment and premises on cleaning logs, which confirmed staff were cleaning regularly and in line with policy.

## Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

The service had suitable facilities to meet the needs of the patients and their families. The service had two main scanners: a magnetic resonance imaging (MRI) and a Magnetoencephalography (MEG) scanner. These scanners were fit for purpose. The MRI had high speed gradients making it suitable for the work undertaken. However, its diameter was only 60cm; this meant that patients who had a larger BMI would not be able to have a scan at this service. The service asked patients for their height and weight upon booking their appointment to avoid on the day cancellations. Staff completed daily quality assurances on the MRI scanner which were recorded. They called the manufacturer if these were outside of the standard required.

The service consisted of a waiting room, MRI suite which included changing facilities and a waiting area, MEG Unit, file store, patient changing room and accessible patient toilet facilities. The waiting area had oversight from the reception desk meaning that patients and visitors were not left unattended. There was also an analysis suite with specialised computers and software for MEG and MRI analyses. The MRI scanning room had 'relax and view' panels with landscape views to minimise the clinical look of the room. There was water available in the waiting area for the MRI scanner.

There was appropriate MRI safety signage as required. There was effective use of these signs throughout the department. For example, the weighing scales had a Magnetic Resonance (MR) unsafe sticker on them and remained outside in the waiting room; this was a sticker which highlighted whether an item was safe to be within a certain distance from the scanner.



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There was a 'fire box' within the MRI scanning room to assist the emergency services in case of a scan room fire. This was brought in following a fire drill in May 2022. They completed fire alarm checks weekly and a member of staff had completed their fire warden training. Their fire alarm had a voice which advised if evacuation was necessary or not. There were walkie talkies within the fire box which were also tested weekly.

The service was managed overall by Aston University. This meant that they followed their policies and procedures such as the health and safety policy. The service completed monthly health and safety audits which looked at the building itself; these were completed and monitored by the university facilities team. We saw that action plans were completed. For example, we saw there was a cupboard which was in the way in one of the rooms and 2 days later this was removed by the facilities team. They also completed an annual report that looked at the training records, risk assessments, standard operating procedures, warning signs, eye protection and safety features; this was completed in December 2022 and was 100% compliant with no actions needed.

Each clinical area had an emergency buzzer. Staff responded quickly when called. Whilst we were on site, the emergency buzzer sounded, and the staff acted quickly; it was found to be within another clinical facility within the building and the staff were not required.

The design of the environment followed national guidance. Clinic spaces were compliant with Health Building Note 00-10 Part A Flooring. All flooring was laminated and included coving to ensure effective cleaning. There were hand washing basins in each clinical area and a foot pedal operated clinical waste and domestic waste bins.

The service had enough suitable equipment to help them to safely care for patients. All single use equipment that we checked was in date. All equipment was within service date and there was a good maintenance programme in place. The MRI and MEG scanners were covered by a service contract supplied by an external contractor; they were regularly serviced in accordance with the manufacturer's instructions. We were told that if there were concerns with the MRI scanner, the manufacturer was very responsive and would either remotely assist or send an engineer on the same day if it affected the service delivery. We saw that daily and annual checks had been completed and all scanners had the appropriate MR Safe labels in place. All electrical equipment had been tested within the last 12 months. The MRI and MEG scanners were serviced annually.

The MEG scanner had 24 hours a day 7 days a week electrical monitoring programme. This meant that if there was a concern with the scanner, their system would alert head office and send a text message to the registered manager to alert them of the concern. We were told that the main issue was likely to be helium recycling. We were told that 6 months ago the servicing company alerted the manager that the helium was going down as they were monitoring it and they had sent someone to fix it immediately.

Staff carried out daily safety checks of specialist equipment. Staff checked resuscitation equipment daily when the clinic was open. We saw staff recorded when these checks had been carried out and all checks had been done in line with policy.

Staff disposed of clinical waste safely. The service had an external contract for the management of clinical waste.

### Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and removed or minimised risks.**



## Diagnostic imaging

Staff completed a safety screening form for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. This included questions around their medical history. Staff reviewed this prior to the patient undertaking their scan to ensure that they were suitable. There were processes in place to ensure the right person had the right scan at the right time. This included clear protocols for referral and a 3-point checking policy for identification. They also utilised the Society of Radiographers 'Pause and Check' process.

Patients were referred for an MRI once appropriate diagnostic imaging had been completed and further images were required. Referrals for MEG scans were accepted for patients who were on the presurgical evaluation pathway for epilepsy only. For both scans, patient compliance was discussed during the referral process. The service offered repeat appointments to patients when a lengthy examination was not tolerated in a single visit. There were risk assessments in place for if a patient had a high level of anxiety or a panic attack and included measures to reduce these where possible. These included reassurance, careful instructions, and careful patient screening prior to the scanning.

Staff responded promptly to any sudden deterioration in a patient's health. The clinic was not an inpatient unit and did not see patients that were acutely unwell. If a patient was not well enough to have a scan, this would be re-scheduled. Training, process, and systems in place for deteriorating patients were suitable for the clinic environment and the level of treatment provided. There were always 2 members of staff within each scanning facility for every patient seen.

There was a resuscitation trolley at the clinic which contained the correct equipment in line with the Resuscitation Council UK (RCUK) 2021 guidelines for both adults and children; this was checked daily when the clinic was open. Staff displayed the RCUK paediatric and adult algorithms for resuscitation, but these were from 2015 and out of date. We informed the staff and they printed out up to date guidance whilst we were on site. Staff had training in basic life support for adults and children and were further supported by guidance in the form of a standard operating procedure (SOP) for the removal of a patient from the scanner in an emergency. Staff we spoke to were aware of their responsibilities and the process to follow. We were told that they had performed practice evacuations of patients from the scanners.

The service had appointed a suitable MRI safety expert (MRSE) from the regional radiation protection service. They had regular and good communication with the safety expert. They undertook acceptance testing for the current scanner which was commissioned in May 2022 and completed a MRI Quality and Safety assessment report in March 2023; both were comprehensive and actions had all been completed. The MRSE undertook an annual quality audit. They also had a contract with the service to advise and support the staff with any radiation issues. The service had also trained 2 members of staff to be accredited MRI safety officers (MRSO); this was a commitment to the safety of the MRI service.

They calculated patient's specific absorption rate (SAR) based on their height and weight. This was to ensure that the scanner used the right amount of energy to produce the scan without overheating the patient; we saw staff record the specific energy dose used in the patients record for the procedure.

There was a comprehensive document which covered all aspects of MR Safety and MEG safety. Both included local rules and operating procedures which had been implemented and were easily accessible for all diagnostic staff to follow. The local rules contained relevant information as required by MHRA safety guidelines for MRI Equipment in clinical use (February 2021). However, they were currently out of date as the current version had not yet been ratified; they had made some amendments to the policy following advice from the MRSE.



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Staff knew about and dealt with any specific risk issues. Staff ensured that women (including patients and staff) who were or may have been pregnant always informed a member of staff before they were exposed to any radiation. The safety screening questions also included questions around foreign body implants, such as pacemakers and other metallic implants. There was a policy in place to ensure that patients and staff did not take any metallic objects, such as jewellery, near the magnetic resonance imaging (MRI) scanner.

Patients were given a control device to stop some tests if they felt unsafe or worried. Within the MRI scanner, if patients were anxious and required more than 1 body part scanning, they would allow the patient to get off the scanner and read a book between the scans to ensure that they were comfortable.

Patients were given 2 types of ear protection, ear plugs and ear defenders to help reduce their discomfort with the loud noise of the MRI scanner.

The service had clear processes to escalate unexpected or significant findings both at examination and upon reporting and staff knew what to do. However, there was no written policy for this. We were told they had not had to escalate any unexpected findings. Following our inspection, we were sent a newly written policy which was comprehensive and listed necessary action to take. There were different pathways depending on whether the patient was an NHS patient or a private patient. For NHS patients, who were all paediatric patients, the images would be sent to the children's hospital and ask for an urgent review by a radiologist. Staff would take the necessary action, for example, the patient would be sent to the children's hospital for an urgent assessment. For private patients, they would send the images to the radiologist and ask for urgent reporting.

There were arrangements in place to deal with emergencies. They also had facilities to ensure they could still operate equipment and continue to meet the care needs of the patient if there was a power cut.

There was an application which all staff had called 'safezone' which was linked to the University. Whilst staff did not work alone with patients, they could be working alone in the office environment. This meant they would check into this application when they arrived at work. There was also an emergency 'SOS' button which alerted the university campus safety team. We were told that they were very responsive.

## Staffing

**The service had enough staff with the right qualifications, skills, training and experience to keep patients safe and to provide the right care and treatment.**

The service had enough staff to keep patients safe. The clinic was very small and only ran services on Monday to Wednesday. They had 4 permanent senior clinical radiographers, including 1 of the registered managers, whose hours all equated to 1.6 full time equivalent members of staff. There were bank staff who assisted where required. There was a lead for the MEG service who was the other registered manager, and several approved researchers who supported the MEG service having undergone advanced training. There were always 2 radiographers on duty and staffing levels were consistent. There were also 2 administrators, the clinical director and 1 technical team member who facilitated MEG scans only. At the time of the inspection, they had a seconded psychology student who had worked in the service since September 2022 and were completing a year long placement 3 days a week at the service.

The service had no vacancies and no turnover of staff. Managers said that the team was consistent and stable. They had not cancelled or moved any scans due to staff sickness within the last few years.



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They used bank staff who had all received an induction and worked regularly within the department. They had recently recruited 2 bank staff who were researchers who would do additional scanning of clinical patients where required.

The service worked with 3 radiologists who reviewed and reported on the scans for private patients; they were employed by the service using practising privileges.

## Records

**Staff kept records of patients' treatment. Records were clear, stored securely and easily available to all staff providing care. However, we found that 2 out of 5 consent forms were not completed fully.**

Patient notes were stored securely, and all staff could access them easily. All patients completed a consent and safety screening form and had a doctors referral letter. Patient's paper records were scanned onto the computer and stored securely; the paper records were stored in a locked filing cabinet. All scans were uploaded from the scanner to a USB stick, this was then transferred to the local children's hospitals system. They then informed the hospitals team that they had uploaded the images to their computer system.

Private patient's images were scanned and reported to the reporting radiologist via an encrypted mail system, the report was returned within 24 hours and the patients receive this on a disk.

Data regarding the patients was obtained prior to the scan. For example, previous scans, recent surgery undertaken, metal work in their body and any electrical devices.

We looked at 5 sets of records. We found that 2 out of the 5 were not completed fully. In 1, the consent form was not signed by the radiographer, and in the other 1, there were 2 questions that the patient had not completed. We fed this back to the manager who stated that they did not do any audits of the consent form and were not aware that this was an issue. Consent and further checks were also completed verbally prior to the scans taking place.

## Medicines

**There were no medicines stored on site.**

## Incidents

**The service managed patient safety incidents well. Staff recognised incidents reported them appropriately. Managers investigated incidents and shared lessons learned with the team. Managers ensured that actions from patient safety alerts were implemented and monitored.**

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the service's policy. There were no patient safety incidents or clinical incidents in the last 12 months. However, we saw 4 incidents had been recorded since 2021 and they had all been investigated and actions taken place where needed. As a result, a 2-person check was introduced. There was an incident reporting policy in place. All incidents were logged on paper forms and reviewed by the managers. We saw in June 2023 CQC management meetings that they highlighted there had been no incidents and they were to remind staff of the need to also report near misses.

The service had no never events or serious incidents.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable



## Diagnostic imaging

safety incidents' and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The staff could explain the process they would undertake if they needed to implement the duty of candour because of an incident, which was in line with the requirements. We saw leaflets available for patients within the waiting room explaining the duty of candour.

Staff received feedback from investigation of incidents, and they met to discuss the feedback and look at improvements to patient care. The monthly governance meetings looked at incidents, complaints, audits, and anything that had been raised. There was evidence that changes had been made because of incidents. For example, they had seen 2 patients who did not fit in their MEG scanner as their head did not fit into the helmet they were required to wear; they used a fixed helmet size. They reported these as incidents, reviewed the policy and now take measurements in advance to ensure that patients can fit.

### Is the service effective?

Inspected but not rated 

We did not rate effective.

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.**

Staff followed policies to plan and deliver high quality care according to best practice and national guidance. Staff knew how to access policies however they were not always up to date. For example, the records management policy was due for renewal in December 2019. We were told it was under review and would be ratified within the next month. They had appointed a Caldicott Guardian in June 2023 and were awaiting this prior to completing the policy. The managers told us that they reviewed the policies annually and they were ratified at clinical governance and medical advisory committee meetings. We saw that policies were discussed at these meetings. We were told that all their radiographers worked elsewhere and brought back good practice and guidelines and shared their learning.

All policies and guidance for staff were based on recognised national best practice guidance such as, National Institute for health and Care Excellence (NICE). We saw evidence of staff updating policies and guidance regularly to reflect changes in national guidance.

The care and treatment reflected relevant research and guidance. We were told that they were developing tests for some medical conditions such as photosensitive epilepsy and they applied their research when treating clinical patients who used the service. They performed functional MRI scans which asked the patients to complete tasks whilst they were on the scanner, such as memory test or test their language skills, and these test certain areas of the brain. The staff then ran a sequence within the scanner whilst the patient was performing the tests which looked at blood oxygen levels and correlated the results. These results gave clinicians further information which they could use to decide on treatment plans such as surgery. These results fed into studies which saw how best patients responded to these types of scans which helped to create management plans for future patients.

The MEG department had recently implemented working groups which were research based and looked at standard operating procedures, ethics documents and ensured they were up to date with guidance.



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## Pain Relief

The service provided was not an inpatient facility and therefore, patients were only at the clinic for short periods of time. Medication was not available on site for pain relief as this was not required.

## Patient outcomes

**Staff had started to monitor the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**

Outcomes for patients were consistent and met expectations. The patients attended for scans, the images were completed, and these were sent to the NHS to be reported; the service were responsible for the images only. We were told that they rarely had a scan which was of poor quality and required to complete again.

The clinical lead provided informal feedback on image quality and positioning to the other radiographers whilst they were working alongside them. In the last 6 months, they had only had one image recall by a radiologist. We were told that as radiographers always worked in pairs, they were constantly checking each others images and working together to achieve the best quality image.

## 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. However, we were not assured that all appropriate recruitment checks had been completed.**

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. There was a recruitment policy and process to ensure the right staff with the right skills, knowledge and qualifications were appointed at the clinic. We asked for evidence of a full employment history check, referees, professional body checks and Disclosure and Barring System checks for 2 members of staff; this information was not provided. We were not assured that all recruitment checks were undertaken. All recruitment services were managed by the University HR department. The service was run by a radiographer and a psychologist with a PHD in neuroscience. All radiographers were registered with The Society and College of Radiographers; and their Health and Care Professions Council (HCPC) registrations were checked annually.

Managers gave all new staff a full induction tailored to their role before they started work. The induction process lasted until they were competent. It included supervision and a competency checklist; all staff had to complete a training programme before they could use the equipment. Competencies were specific to job role and were documented in staff records. These were all reviewed every 2 years in line with the HCPC renewal. There was also a matrix of training which included supervision hours for the MEG scanner; we saw a member of staff had completed 18.5 hours of shadowing prior to operating the scanner. Staff always worked with another member of staff whilst operating the scanners. We reviewed 2 staff files and found completed induction and competencies in both records.

Managers supported staff to develop through yearly, constructive appraisals of their work, they were called 'my development conversation'. We were told 100% of staff had had a recent appraisal. We looked at 2 completed appraisals which were comprehensive. All staff we spoke with said their appraisals were meaningful, and the managers focussed on development.



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Managers made sure staff received specialist training for their role. We saw that staff were supported with their professional development by their managers and by the University. They were encouraged to attend conferences, complete online courses, and attend study days. They were primarily a research facility and were encouraged to conduct research into improving the medical conditions of people who used the service.

Managers supported staff to develop through regular, constructive clinical supervision of their work. We saw that the managers were often clinical and worked alongside the radiographers and were able to give constructive feedback often, if required. At the time of our inspection, there was a psychology neuroscience student who had been with the service for 10 months. This was the first time that the service had worked with a student. They supported the student through competencies and regular supervision to increase their confidence and competence.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The service had put 2 of their radiographers on the accredited MRI safety officer's course; this was a commitment to developing their skills and knowledge whilst ensuring the safety of the MRI at all times.

Managers were able to identify poor staff performance and would support staff to improve. However, they had not had to implement performance management as all staff had performed well at their service; systems were in place should it be required.

Staff working under practising privileges had checks on their mandatory training, safeguarding of children and adults and life-support status. We looked at 2 consultants files who were under practising privileges. We found they had up to date appraisals, indemnity insurance and had signed the practising privileges contract. They provided radiology reports on private patients which was sent to them electronically; they were not patient-facing.

## Multidisciplinary working

### **Staff worked together as a team to benefit patients. They supported each other to provide good care.**

The team worked well together and communicated effectively for the benefit of the patients and their families. This included the registered manager, radiographers, bank staff, administrators, and radiologists.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their experience. We saw evidence of changes staff had made following team meetings where patient feedback had been discussed.

We observed positive staff working relationships which promoted a relaxed environment and helped put the patients and their families at ease.

Patients were referred to the service by doctors who provided information to the service so they could ensure the patient had the most appropriate treatment. They liaised with and produced reports for other providers which recommended any further actions needed for the patients following the scanning. There was a referral checklist in place which was used to ensure all the providers involved in the patients care received the appropriate information when necessary. A senior radiologist justified the MRI request and added the required protocol; this patient would be allocated to this provider or within the NHS depending on what was required. For example, they did not see patients who required contrast scans or complex medical needs; these would be done at the local children's hospital.

The service completed a report which looked at the average number of days from the scanning appointment to the report being completed; on average in 2023, it took between 0.3 and 1.6 days to complete the report.



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## Seven-day services

### Key services were available to support timely patient care.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests. The service was small and only open clinically Monday to Wednesday and on Thursday and Friday for research only; the service was primarily a research facility. Patients could book appointments by telephone or via email.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

#### **Staff supported patients to make informed decisions about their care and treatment. They mostly followed national guidance to gain patients' consent. However, we found that the consent forms were not always completed fully.**

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They were only able to see patients who had capacity as they were required to understand that they needed to lay still within the scanner and understand the instructions that they were being told whilst within the scanner.

Staff gained consent both written and verbal from patients for their care and treatment in line with legislation and guidance. Staff mostly made sure patients consented to treatment based on all the information available. There was a consent form and policy which showed that staff discussed the benefits, alternatives, risks, and consequences if examinations were not undertaken with the people who used the services. We observed 2 episodes of care where full checks and consent was undertaken to have the scan.

People who used the service were supported to provide consent and they were given information in a format which they could understand and was appropriate for their age. For example, they used child friendly videos to explain some procedures. The risks and benefits of the scans were also displayed in the waiting room for patients to read. Patients were able to withdraw their consent at any time because staff sought consent from people before every examination. During some treatments, patients were given a control device so they could stop the examination at any time.

Staff told us they would discuss examinations with children and seek consent from family members with parental responsibility. Staff supported children who wished to make decisions about their treatment. They had different types of consent forms for children in a language that was more appropriate for their age. They also had information sheets in 2 different age categories to help patients understand their treatment. Staff understood consent and knew what was required to support children under the age of 16 years old in making decisions about their care and treatment. They had already made the decision to have a scan when they attended the service. However, if a child refused to have a scan, they could not force them to do so. We were told about a challenging patient who took over an hour to consent to have the electrodes put on their body, but through gentle reassurance, they were able to complete the scan.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

## Is the service caring?

We rated caring as good.



# Diagnostic imaging

## Compassionate care

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

Staff and leaders promoted strong, caring, respectful and supportive relationships with their patients. Staff were passionate about ensuring there was a strong and positive patient-centred culture at the clinic. They focussed on patients feeling valued, important and cared for every time they entered the clinic. Feedback from patients was continually positive with patients expressing their care and support exceeded their expectations. We read feedback where the service was described as “perfect” and “amazing with my child”. We saw staff interact with patients on arrival and throughout their time at the clinic with compassion and kindness. We saw all staff had a fantastic attitude towards patients and students who were training during the appointments. Staff took time to interact with patients and those close to them in a respectful and considerate way. Parental comments in their feedback included, “very helpful at keeping my son calm” and “information given was excellent and more than helpful in answering any questions. They were reassuring towards my daughter throughout the whole process”. Each appointment for an MRI scan was 1 hour long and for an MEG was 3 hours; this meant that the staff had time to spend with each patient ensuring that they were comfortable prior to their scan.

Consideration of patient’s privacy and dignity was consistently embedded in everything staff did. Staff followed policy to keep patient care and treatment confidential. The registered manager and staff kept all information stored securely with password protection on electronic patient information.

The staff had mechanisms to reduce the anxiety for patients which included taking their time and thorough explanation of the scan itself. In the MEG scanner, they also had a small toy which also wore a helmet on their head, and they were able to use this to demonstrate what would take place within the scanner. Within both scanners, the patients were able to watch something that they enjoyed; there was a system of projection and mirrors set up to enable patients to watch a video to help them cope with lying still. We were told that this often was what made the children less anxious, as they were able to watch their favourite programme. Staff used stickers and rewards for children in 2 age-appropriate styles following their procedure. The MRI suite also contained a floral landscape viewing panel and wall decoration which reduced the clinical look of the room.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff showed a non-judgemental attitude when caring for or discussing patients with additional needs.

## Emotional support

**Staff provided emotional support to patients, families and carers to minimise their distress. There was a strong, visible person-centred culture that was inclusive and understanding of patients’ personal, cultural and religious needs.**

Staff gave patients and those close to them help, emotional support and advice when they needed it. They supported patients who became distressed in an open environment and tried to reduce patients’ anxiety by providing patient-centred care. We were told that a researcher created a storyboard for a paediatric patient who had autism prior to their scan to show them what was going to happen and alleviate their anxiety. Where patients became distressed during their scans, the scans were stopped immediately, and the patient was attended to. They were also given time between scans if they needed. We were told that if a patient was anxious, they would let them read a book between scanning of different areas.



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Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

## Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We saw that staff really listened to the needs of the patients. For example, they found that children did not always feel comfortable removing their glasses for their MRI scans as this meant they were not able to watch a video to help them through the scan. They had therefore sourced safe, non-metal glasses with a range of different prescriptions for them to wear whilst in the scanners. They also allowed children to bring a soft toy with them, following a check of MRI safety. Staff asked the child the name of the soft toy so that they could involve it in the care with the child.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There were 2 surveys that patients could complete; one was child friendly and was smiley face orientated and the other was for adults to complete. Their main theme that came out from the survey results was that people struggle to find the building. They had since brought in a QR code that brings patients directly to the building. Since bringing this in, they have not had any further comments about this.

We spoke to 2 patients and their families. The child told us the staff were very kind, and they liked the radiographer. The staff had stopped the scanner when the child pressed the buzzer, and the mother was very appreciative of this and that they did not force the child to carry on when they were clearly ready to stop.

Patients gave positive feedback about the service. The service undertook a patient satisfaction survey. We saw that this was last completed in January 2023 where they had received 33 responses with only 1 negative review. This review was negative not due to the service, but they said they were fed up with hospital tests. Comments within the satisfaction survey included "so friendly, efficient and professional, love the music thank you", "like Mary Poppins, practically perfect in every way, keep up the awesome work" and "the healthcare professionals made me feel at ease when initially feeling very anxious, they went above and beyond". One child enjoyed their scan so much they asked if they could stay all day.

There was a satisfaction survey for the MEG service completed in April 2023 where 100% of patients would recommend the service.

## Is the service responsive?

Good 

We rated responsive 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.**



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Managers mostly planned and organised services so they met the changing needs of the local population. The service was mainly a research facility and was open 09.00 until 17.00 Monday to Wednesday for clinical patients. It was open on Thursday and Friday but for research purposes only; no clinical scans were performed. The service saw NHS patients were paediatric patients who were referred from the local children's hospital, private patients, and research patients. The service stated that this satisfied the demand that they received. They were able to open on a weekend for a scan if required, but this was not often needed.

The service minimised the number of times patients needed to attend by ensuring patients had access to the required staff and tests on 1 occasion. They saw patients who were referred by a consultant, referred themselves or were referred privately. The service was open to tertiary MRI and Magnetoencephalography (MEG) referrals only. Patient who required a MEG scan were referred via the NHS pathway. They did these scans on average twice a week. They were usually performed within 6 to 8 weeks of receiving the referral. They needed clinic notes and a structural MRI image completed, or to make time for that to be done whilst they were on site. They could mostly offer an MRI scan within 48 hours of receiving the referral.

Facilities and premises were appropriate for the services being delivered. The clinic had a car park with ample parking and designated disabled parking spaces available. The clinic was easily accessible for patients with mobility issues or wheelchair users' access with ease. There was enough seating in the waiting area.

Managers ensured that patients who did not attend appointments were contacted, and appointments were rescheduled.

The service relieved pressure on other departments when they could treat patients in a day. Appointments were often available within 48 hours where required. The service had no waiting list and were able to support a walk-in service for patients who were at the local children's hospital; this was offered 2 mornings a week.

## 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.**

The service provided MRI and MEG scans for both NHS and private referrals and for research patients.

Managers made sure staff, patients, and their families could get help from interpreters or signers when needed. All patients who required an interpreter had these booked in advance of their appointment.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. We were told that they saw children who were diagnosed with autism and made provisions were possible to make their treatment as comfortable as possible. For example, if they were unable to tolerate crowds, they would ensure that there was no one in the waiting area. We were also told that a researcher created a storyboard for an autistic child to help them understand the service prior to undertaking their scan.

The service had information leaflets available in English only but stated that if it was required within another languages, they would be able to facilitate this within the inclusion department at the University.



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The service was set out so patients with limited mobility could access all areas. The doors were wide enough for a wheelchair user and there were accessible toilets on the ground floor. The MEG had a ramp which could be lowered to assist with access into the scanner.

As part of the referral letter, the staff requested the patient's clinic notes and this gave an indication of the patients' background. Depending on the information found within the notes, they would ask certain questions prior to attendance to ensure that the patient was comfortable with their scan. For example, some scans need to be done sleep deprived so they gave this information to the patient in advance of the scan to ensure they had less sleep the night before. The service had invested in a premium online subscription to allow children to watch films whilst they were having their scan via the projection system. We were told that management supported investment into patient comfort systems.

Parents or carers could sit in the MEG or MRI scanning rooms with the patient and hold their hand as long as they stayed still and removed all metal work from their person.

The MRI team had a mini MRI scanner model for patients to look and play with whilst they were waiting for their scan.

## Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed. Patients requesting urgent appointments were seen within 1 week of the request, often within 48 hours.

Managers worked to keep the number of cancelled appointments to a minimum. Patients mostly did not cancel their appointments but if they did, they were rescheduled without any concerns. The administrators called the patients if they did not attend and rebooked them. The service had low numbers of failure to scan patients. They recorded that 100% of MEG patients attended, 100% of private patients attended and 98.8% of patients attended for an MRI from the children's hospital. This equated to 2 patients; 1 who was unable to tolerate their scan and the other who's referral failed to declare the patient had a cochlear implant which was a contraindication for an MRI.

## Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. They had not received any complaints in the last 2 years. However, if they did, managers told us they would investigate them and look at any themes and make any changes needed to improve the service.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. They had not had any formal complaints, but they had received some comments within their patient survey which they had actioned. For example, several patients mentioned that they found it hard to find the service. They had created a QR code which dropped a pin at the location; patients could use this with their satellite navigation



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to find the building. They were also asked to communicate more information about hair styles and hair products that patients could use whilst undertaking the MEG scanning; the service updated their information leaflets to include more information about this. They communicated these changes to patients via a 'you said, we did' poster in the waiting areas.

### Is the service well-led?

Good 

We rated well-led as good.

### 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. They supported staff to develop their skills and take on more roles.**

The service was very small with 8 members of staff. It had a clear leadership structure in place. There were 2 registered managers, one who was a clinical radiographer and the other who was the lead for the MEG service. There was also a clinical director who ran the service alongside the managers.

The managers were aware of the service's performance, limitations, and the challenges it faced. We were told that one of the main challenges was running the clinical service alongside the research service and making sure that it all aligned. The service was mainly a research facility but the need for clinical scans was increasing, and the challenge was to be able to complete these alongside the research scans. The MRI had limitations due to lack of medical support on site; they therefore did not complete contrast MRI scans or scans which required sedation.

Staff told us the managers were friendly and approachable. Staff felt confident to discuss any concerns they had with them and were able to approach the manager directly, should the need arise. One of the registered managers was always on site when the clinic was open for clinical patients.

Regular communication took place between the registered manager and staff. Senior radiographers worked closely with the registered managers to ensure all relevant radiation legislation was followed and any concerns with the equipment was addressed. Staff were invited to attend meetings which took place such as clinical governance. Due to the small number of staff in post, staff saw each other on a regular basis to discuss any issues affecting the service. They had regular team meetings. Managers made sure staff attended team meetings or had access to full notes when they could not attend. Senior staff held team meetings regularly and all meeting minutes were uploaded to the computer for staff to see.

### Vision and Strategy

**The service had a vision for what it wanted to achieve. Leaders and staff understood and knew how to apply it and monitor progress. However, there was no strategy for the service.**

There was a clear vision and objectives for the service. They were very patient focused and this was evident with the care that the patients received.



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The service had a vision for both the clinical and research side of the service. The clinical service wanted to provide the best care they could for the patients who come through the door. They wanted to be flexible and offer an excellent patient experience. The research vision was to make the facility accessible and make it a world leading research centre which was very child centred. We were told that it was a paediatric centre for neurodevelopment and there were many elements that fed into this research including nutrition, cellular recording, and educational areas.

Staff were aware of the vision of the service, and this was discussed within their meetings. The research team had undertaken away days which were primarily focussed on the academia but always invited the core clinical team. They had recently enjoyed an away day at the botanical gardens where the managers gave the team an overview of the service and guidance on the next steps required.

There was no documented strategy for the service and how it wanted to develop over the next few years. Managers were not clear on what the strategy was or if one had been developed. This meant that there was a potential that there was no clear business focus for the service and priorities could be misaligned from a research and clinical perspective.

## Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**

Staff felt supported, respected, and valued. Staff worked together as a team to identify and address concerns to continually improve.

Staff felt positive and proud to work at the organisation. The culture was centred on the needs and experience of patients and staff consistently demonstrated passion towards putting patients first.

The culture encouraged openness and honesty. Leaders and staff understood the importance of staff being able to raise concerns without fear.

There were mechanisms for providing all staff with the development they needed, such as high-quality appraisals and career development conversations; staff told us that they felt supported to develop.

The organisation was committed to the safety of their staff. They had an application which supported staff if they were lone working and meant they could immediately contact security if they felt in danger.

Cooperative, supportive, and appreciative relationships amongst staff were present. Staff worked collaboratively as a team, they resolved conflict quickly and constructively.

There was a poster in the staff room for an employee assist programme to support staff who feel they might need counselling; this would be paid for by the service.

## Governance

**Leaders had governance processes in place. 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. However, due to a lack of audits performed, we were not sure that the managers had a good understanding of the service's performance.**



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There were effective structures, processes, and systems of accountability to support a good quality sustainable service. Senior staff regularly met to review these and made improvements when needed. The team was very small, and the leaders worked closely with the staff on the ground. This enabled effective two-way communication channels for raising concerns and providing feedback.

The service had a good governance structure for the size of its service. They had a quarterly clinical governance (CG) meeting followed by a medical advisory committee (MAC) meeting a month later. They also had CQC managers meetings monthly with both registered managers and the clinical director and a senior operations meeting.

The CG meeting was attended by the leads for the service, health and safety, and was supported by the University on a quarterly basis. There was a statement of purpose for the clinical governance committee which outlined the structure and the key roles of the meeting. They also held the MAC a month after each clinical governance meeting which had infection prevention and control input and radiologists in attendance. They were attended by senior management and discussed incidents, complaints, policies, and procedures. However, there was a limited number of audits performed. This meant the managers were not always aware of potential issues within the service or able to assure themselves about the service's performance. For example, record audits were not completed; this meant managers were not aware consent forms were not always completed fully. The service used to undertake image quality audits in the past with feedback from a consultant radiologist; this was an informal process. They did not do any image quality since they had the new scanner commissioned in 2022. Following the inspection, the managers sent through an audit they had created to review the quality of images. They had completed this for July 2023 for 5 images which showed overall there was a good quality of images. There was one suggestion of improvement needed regarding positioning as some images were not straight however there was a lot of movement from the patient which reduced the quality of the image; this audit was to be completed every 6 months.

The MAC was led by an external consultant who worked at the local children's hospital. We reviewed the minutes and saw that they reviewed the CG meeting minutes and reviewed policies, audits, patient satisfaction, and any other business.

The radiographers also met every 3 weeks either face to face or via video calls. We were told as they were such a small team, they discussed any issues as they arose. There was a communication book within the MRI control room which the MRI clinical lead left messages for staff if required.

The service had service level agreements (SLAs) with local NHS trusts to ensure staff had appropriate advice regarding infection prevention and control and safeguarding. They were supported by clinical radiologists when they needed advice regarding information found within a scan. There were also SLAs in place for the monitoring and maintenance of the MEG and MRI scanners.

They had recently employed a new nominated individual who was a neurologist based at the local NHS Children's hospital; they were also the clinical director.

## Management of risk, issues and performance

**Leaders and teams used systems to manage performance. They mostly identified and escalated relevant risks and issues and identified actions to reduce their impact.**

There were assurance systems that allowed performance issues to be escalated appropriately through clear structures and processes. These systems were reviewed and improved as needed.



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Senior staff monitored staff performance through annual appraisals. These focussed on staff development and learning.

Staff working under a regulatory body were required to demonstrate an up-to-date knowledge of their clinical practice.

There were arrangements for identifying, recording, and managing risks, issues, and mitigating actions. The service had risk assessments which were associated with the MEG and MRI scanners and reviewed these regularly to ensure the risks were mitigated. For example, they had robust contracts in place with the manufacturers of the scanners and could call them immediately if there was an issue. This would be prioritised by the manufacturer if it impacted on their patient care.

The managers told us they used the risk management policy from the University. There was no risk register within the service, but they were mostly aware of their risks and had risk assessments for each risk which had mitigations to reduce each risk. Managers told us their top risks were:

- Building risks such as fire.
- Operation risks such as the safety risks that are associated with the MRI scanning.
- Equipment breakdown.

Each research project had its own set of risk assessments attached which were comprehensive. However, we did not see risk assessments for disruptions to the service such as information technology (IT) failures for example.

## Information Management

**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. Data or notifications were consistently submitted to external organisations as required. However, data protection policies were out of date and lacked detail.**

The service collected information through regular team meetings, patient feedback, audit outcomes and external party engagement such as through medical advisory committee meetings. Senior staff used the information from these meetings for improvement and not just for assurance.

The service used IT systems effectively to monitor and improve the quality of care. All audits, meeting minutes, policies, procedures, and guidance were stored centrally on the electronic systems. This was password protected and easy to navigate and use.

Staff knew what data and notifications required submission to external bodies. Staff were aware of the need to report to the Information Commissioner's Office for data breaches, CQC in relation to incidents in line with Care Quality Commission Registration Regulations 2009, and Public Health England.

However, there was a poor quality policy on records management. It was 4 years out of date, lacked detail and was not in line with the most up to date national guidance. The policy did not detail what staff should do if there was an information breach, how this should be reported and who this should be reported to. We raised this at the time of the inspection and were informed that the policy was currently being updated. We saw in the clinical governance meetings minutes from March 2023 that they had highlighted the need for a Caldicott Guardian and this was being discussed with the University. We also saw they had highlighted in their CQC management meeting in March 2023 that they needed a records management policy. Following our inspection, we were told a Caldicott Guardian had been appointed and the policy was being completed.



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## Engagement

**Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

The service gathered and acted on people's views and experiences to shape and improve the services. Staff routinely monitored feedback to analyse trends and themes in both positive and negative feedback and we saw staff had implemented changes when areas of improvement were highlighted.

The staff were passionate about ensuring the culture was open and inclusive, to enable a positive patient experience. They actively engaged in meetings so that their views were reflected in the planning and delivery of services.

The service had positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population.

## Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**

Staff participated in appropriate research projects to strive for continuous improvement and learning.

They had also invested in a 32-channel head coil rather than the standard 20 channel to improve the image quality and shorten scan times.

The MRI functional scans are innovative and research articles have been published following information from these scans performed at this service.