The Leeds Upright MRI Centre

Quality Report

Tower Court
Armley Road
Leeds
West Yorkshire
LS12 2LY
Tel: 01132311902
Website: www.uprightmri.co.uk

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

Ratings

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

Overall summary

The Leeds Upright MRI Centre is operated by InHealth Group.

The Leeds Upright MRI Centre opened in September 2012 following the success of the London Upright MRI Centre which opened in 2006, with the aim to provide the same high-quality services to the people of North England and beyond.

The centre houses the first Paramed MROpen scanner installed in the United Kingdom, and at the time of opening was only the fifth to be installed worldwide. The scanner is also the only upright magnet in North Yorkshire and is the furthest north in the UK.

Magnetic resonance imaging is a medical imaging technique used in radiology to form pictures of the anatomy and the physiological processes of the body in

Summary of findings

both health and disease. Magnetic resonance imaging scanners use strong magnetic fields, magnetic field gradients, and radio waves to generate images of the organs in the body.

The scanner is specifically designed to assist those who may not be able to tolerate a conventional magnetic resonance imaging (MRI) scan for a variety of reasons;

- Claustrophobia or severe anxiety
- High body mass index (BMI) or broad shoulder width
- Unable to lay flat for a variety of reasons
- Have the need of a positional/upright scan to assist in diagnosis

The aim of the centre is to provide a diagnostic pathway for those service users whose care pathways would not be possible through lack of an MRI scan, because they are not able to tolerate the confines of a standard configuration magnet.

The registered manager has developed the scanner alongside the manufacturer since its installation, including sequence development and service user positioning, and the team is experienced in assisting anxious service users.

In February 2019 United Open MRI Ltd was purchased by InHealth Group.

We inspected this service using our comprehensive inspection methodology. We carried out a short notice announced inspection on the 12 November 2019.

To get to the heart of service user 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.

During the inspection we spoke with four staff, four service users and one relative. We reviewed 10 sets of service user notes, five consent forms and reviewed four staff files.

Services we rate

Our rating of this hospital/service stayed the same. We rated it as Good overall.

We found good practice in relation to:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect service users from abuse and when to contact other agencies to do so.
- The service had suitable premises and equipment and looked after them well.
- Staff completed risk assessments for each service user.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment
- The service provided care and treatment based on national guidance and evidence of its effectiveness, monitored the effectiveness of care and treatment and used the findings to improve them.
- The service made sure staff were competent for their roles and staff worked together as a team to benefit service users.
- Staff understood their roles and responsibilities under the Mental Capacity Act 2005 and in relation to informed consent.
- Staff cared for service users with compassion and provided emotional support to service users to minimise their distress. Feedback from service users confirmed that staff treated them well and with kindness.
- Staff involved service users and those close to them in decisions about their care and treatment.
- The service planned and provided services in a way that met the needs of local people.
- The service took account of service users individual needs and people could access the service when they needed it.

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- The service investigated incidents and complaints, learned lessons from the results, and shared these with all staff.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service collected, analysed, managed and used information well to support its activities, using secure electronic systems with security safeguards.
- The service engaged well with service users, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The service was committed to improving services.

However, we also found the following issues that the service provider needs to improve:

- The service did not adhere to standard labelling of equipment in line with MHRA best practice for example; MR safe, MR unsafe and MR conditional. We found fire extinguishers stored outside the MRI scan room were labelled with manufacturer non specific labelling.
- The service did not adhere to MHRA best practice following contractual servicing of machinery, fault repair or physics quality assurance (QA) checks. The service did not use staff hand over forms following servicing and or repair of machinery to evidence quality assurance.

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

Ann Ford

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	We rated this service as good overall with ratings of good for safe, caring, responsive and well-led. CQC does not rate effective for diagnostic imaging services. There were areas of good practice and a small number of things the provider must do to improve. Details are at the end of the report.

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Background to The Leeds Upright MRI Centre

The Leeds Upright MRI Centre is located at Tower Court, accessed from Armley Road which is a shared set of offices with two other companies based in an old school house. The service is located on the ground floor with ample parking to the front of the building. The service was accessible via intercom access and had a large waiting room with disabled access toilet facilities. In the waiting area was a small kitchenette accessed by staff only and an imaging services managers office. There were two changing rooms accessed via reception leading to the sub-waiting area, which had another disabled toilet. To the rear of the building was a staff room and a server room which housed the single 0.5 Tesla Open and Upright MRI scanner.

The service opened in September 2012 as a single modality Upright and Open Magnetic Resonance Imaging (MRI) diagnostic centre service for NHS and self-funded service users. A new self-referral service launched at the end of November 2018.

Since the last inspection the service now accepts service user self-referrals, allowing service users to take greater control of their own health. This service is regularly reviewed and modified to better serve the needs of the user.

The service has recently amended regulated activities (October 2019) to treat children eight years and over. A local statement of purpose was available.

The service had direct general practitioner (GP) referral pathways with some local Clinical Commissioning Groups (CCGs), under which the service can commission activity on their behalf if the service user meets certain agreed criteria.

The service is registered with the care quality commission to provide diagnostic and screening procedures to adults and children over eight years of age.

The clinic's registered manager had been in post since May 2019

Our inspection team

The team that inspected the service comprised a CQC lead inspector, an assistant inspector and a specialist advisor with expertise in radiology. The inspection team was overseen by Sarah Dronsfield Head of Hospital Inspection.

Information about The Leeds Upright MRI Centre

The Leeds Upright MRI Centre is registered with the CQC to undertake the regulated activity of diagnostic and screening procedures. The service provides magnetic resonance imaging (MRI) scans from the Leeds Upright MRI Centre. Reporting is undertaken by three qualified consultant musculoskeletal radiologists who work with InHealth under practising privileges arrangements.

The service was accessible to people living with a disability. The Leeds Upright MRI Centre employed four staff. The service is open Monday to Friday. The service scans adults and children (over eight years of age).

The Leeds Upright MRI Centre provided Magnetic Resonance Imaging (MRI) scanning for service users in a range of positions. The scan is an open scanner making the scanning of claustrophobic service users less stressful.

During the inspection, we visited the service centre in Leeds. We spoke to all staff on duty including; the registered manager of imaging services, two radiographers, one assistant and one reception staff

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member. We spoke with and observed the care of the four service users who visited the unit that day. We also reviewed information provided by the service and looked at online systems and records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The Leeds Upright MRI Centre had previously been inspected by CQC in January 2014. The service received an overall rating of good.

InHealth were working towards accreditation with QSI (Quality Standards in Imaging)The service was accredited by the following national bodies:

- ISO 9001:2015 which specifies requirements for a quality management system. An organisation needs to demonstrate its ability to consistently provide products and services that meet customer and applicable statutory and regulatory requirements.
- ISO/IEC 27001:2013 specifies the requirements for establishing, implementing, maintaining and continually improving an information security management system within the context of the organisation.
- Improving Quality in Physiological Services (IQIPS) is a professionally led accreditation scheme with the aim of improving services, care and safety for service users undergoing physiological tests, examinations and procedures.
- Investors in people - gold award (December 2016, December 2019)

InHealth were working towards the Quality Standard in Imaging (QSI), formerly imaging services accreditation scheme (ISAS). The director of clinical quality was leading the accreditation preparation. The service was working on the development of evidence for each of the domains i.e. leadership and management, workforce, resources and equipment, service users experience and safety.

The director of clinical quality and clinical governance lead are members of the QSI London region network group which shares best practice and guidance on services working towards accreditation. The service intended to be accredited across diagnostic and imaging services including this location by December 2020.

Activity (October 2018 to September 2019)

- From October 2018 to September 2019, 549 service users attended the service for MRI scans, around 55% scans were NHS funded and around 45% were self-funded. One child (NHS contract) was scanned during this timeframe.

Track record on safety:

- Zero Never events
- Zero Serious injuries
- 10 incidents were reported from October 2018 to October 2019
- Zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- Zero incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- Zero incidences of hospital acquired Clostridium difficile (C.diff)
- Zero incidences of hospital acquired E-Coli
- One complaint

Services provided for the clinic under service level agreement:

- Information technology (IT), cleaning services, clinical waste, equipment maintenance, servicing and repair.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as Good because:

We found the following areas of good practice:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect service users 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 service users, themselves and others from infection. They kept equipment and the premises visibly clean.
- The service had enough staff with the right qualifications, skills, training and experience to keep service users safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.
- Staff completed risk assessments for each service users.
- The scanning room had warning signs displayed.
- Staff kept individual service user's records containing details of scans and reports which were stored securely and were easily accessible to the relevant clinicians.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

However, we also found the following issues that the service provider needs to improve:

- The service did not adhere to MHRA specific guidance surrounding the labelling of equipment for example; MR safe, MR unsafe and MR conditional.
- The service did not adhere to MHRA best practice following contractual servicing of machinery, fault repair or physics quality assurance (QA) checks. The service did not use staff hand over forms following servicing and or repair of machinery to evidence quality assurance.

Are services effective?

We do not currently rate effective for diagnostic imaging services. Effective was inspected but not rated.

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We found the following areas of good practice:

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- All the staff files contained relevant proof of qualifications including practicing privileges, skills and experience, training record, photographic identification and current Disclosure and Barring Service (DBS) checks.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for service users. The service was working towards Quality Standards in Imaging (QSI), formerly ISAS with a view to achieving evidence for each domain in leadership and management, workforce, resources and equipment, service user experience and safety. The service aimed to be accredited across diagnostic and imaging services including this location by December 2020.
- The service made sure staff were competent for their roles.
- Staff of different kinds worked together as a team to benefit service users.
- Staff understood their roles and responsibilities under the Mental Capacity Act (2005) and in relation to informed consent.

Are services caring?

Good

We rated caring as Good because:

We found the following areas of good practice:

- Staff treated service users with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff empowered people who use the service to have a voice and to realise their potential. They showed determination and creativity to overcome obstacles to delivering care. People's individual preferences and needs were reflected in how care was delivered.
- Staff supported and involved service users, families and carers to understand their condition and make decisions about their care and treatment.
- The service specialised in treating service users who suffer with claustrophobia and anxiety. There was the ability for service users to be offered a double appointment providing enough time for magnetic resonance imaging staff to discuss concerns and allow a pre-appointment tour of the facility to reduce service user anxiety.

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- Staff provided emotional support to service users, families and carers to minimise their distress. They understood service users personal, cultural and religious needs.

Are services responsive?

Good

We rated responsive as Good because:

We found the following areas of good practice:

- 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.
- The service was inclusive and took account of service users' individual needs and preferences. Staff made reasonable adjustments to help service users access services. They coordinated care with other services and providers.
- People could access the service when they needed it. Waiting times from referral to treatment were in line with good practice.
- 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 service users in the investigation of their complaint.
- The environment was appropriate, and service user centred.
- Service users were given choices around their appointment times which were discussed at the point of booking.

Are services well-led?

Good

We rated well led as Good because:

We found the following areas of good practice:

- 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 service users and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.
- Staff felt respected, supported and valued. They were focused on the needs of service users receiving care. The service

Summary of this inspection

promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where service users, their families and staff could raise concerns without fear.

- The management team were described as visible, approachable and helpful by staff.
- 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.
- Good team work and support was observed during the inspection.
- The service had a clinical governance framework
- Risks were assessed and recorded and where applicable recorded on the risk register and escalated to senior managers.
- The service held regular health and safety meetings.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	N/A	Good	Good	Good	Good

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Good

We rated the safe domain as good.

Mandatory training

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff completed a number of mandatory training modules, which included; fire safety and evacuation, equality and diversity, infection prevention and control, safeguarding children and adults, data security awareness, moving and handling, customer care and complaints, MRI safety, and basic life support (BLS) training. At the time of inspection compliance with mandatory training was 100% for all staff.
- Staff mandatory training was provided initially through InHealth headquarters during staff induction and then as a mixture of on-line and face to face practical sessions.
- There was a comprehensive induction plan for new starters which was tailored to individual needs. For a trainee new member of staff, the induction period could be up to 12 weeks. Mandatory training, supervised practice and competency assessment were all incorporated into the induction period.
- The overall training records were held by the company human resources department and were recorded on a computer database.
- Individual staff could access the online learning platform to check compliance.
- The service kept a spreadsheet of mandatory training requirements for employees and staff were alerted when retraining or refresher training was needed.
- Mandatory training was discussed as part of the staff appraisal system.
- During the inspection there was evidence in all the staff files of 100% mandatory training compliance.
- During our inspection, we noted that not all staff has been trained in the use of the fire evacuation chair which was scheduled for December 2019.

Safeguarding

- Staff understood how to protect service users 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 had policies in place for safeguarding children and vulnerable adults, which outlined staff responsibilities with regards to discussion with senior staff and reporting to the local authority and/or police as appropriate.
- The policy outlined the principles of prevention of harm and abuse. The policy covered definitions of risk, the PREVENT strategy and staff roles and responsibilities.
- Safeguarding formed part of induction; focussing on preventing people suffering from all forms of abuse and avoidable harm within the service in accordance with intercollegiate guidelines.
- The service had an identified safeguarding lead and deputy trained to safeguarding level four adults and children. All staff were trained to safeguarding level two children and level two adults. We saw evidence all

the staff had up to date children's and adults safeguarding level two training. All staff had access to children and adult level four trained support corporately.

- The staff we spoke with demonstrated an understanding of their responsibilities regarding safeguarding and were aware of who they needed to contact within the service and the local authority if they had a safeguarding concern.
- Contact numbers for safeguarding contacts and police were readily available in site files should staff need to raise a concern.
- Staff had knowledge of current safeguarding issues such as child sexual exploitation and modern slavery.
- Staff told us that children were always accompanied by a person with parental responsibility.
- At the time of inspection, all employed staff and the self-employed reporting consultant radiologists had been checked and verified through the disclosure and barring service.

Cleanliness, infection control and hygiene

- The service-controlled infection risk well. Staff used equipment and control measures to protect service users, themselves and others from infection. They kept equipment and the premises visibly clean.
- The registered manager was the lead for infection, prevention and control (IPC). All staff had undertaken infection prevention and control training.
- There were IPC policies and procedures in use. These provided staff with guidance on appropriate IPC practice for example, cleaning schedules, hand hygiene and decontamination of equipment.
- There was evidence of regular infection prevention and control audits being completed including cleaning schedules for the premises and equipment as well as hand hygiene audits.
- The service had completed a hand hygiene audit in October 2019 which evidenced a compliance rate of 100%. The audit covered hand hygiene cleaning techniques pre and post service user contact and the use of personal protective equipment.
- We reviewed the October 2019 environmental audit. The audit was completed by the registered manager, compliance scores evidenced 72 out of 75 elements had been achieved with a compliance score of 96%. There was an accompanying action plan for the areas where there had not been 100% compliance with action owners and dates for completion.
- During inspection all areas of the clinic appeared visibly clean and well looked after. There were bottles of alcohol hand gel situated around the clinic for staff and service users to use.
- Staff worked bare below elbows and were observed cleaning their hands with alcohol gel after service user's interactions.
- There were gloves and universal wipes and hand wash available for staff to use.
- Staff were observed cleaning the magnetic resonance imaging coils and the scan bed in-between service users. Disposable paper roll was used on the scan bed for service users to lie on which was changed between individual scans.
- Staff told us if they had been made aware through the referral process a service user was infectious they would be scanned at the end of the appointment list and the room and equipment would be thoroughly cleaned down afterwards.
- Staff were observed washing their hands after service user contact. Staff were observed wearing gloves and the glove dispenser was found to be full.
- Cleaning solutions, spill packs and personal protective equipment were available if needed.
- For service users needing cannulation for contrast injections, this was undertaken in the scan room where handwashing facilities were available.
- Cannulas were removed in the scan room and disposed of correctly as clinical waste. In the scan room there was personal protective equipment including gloves and aprons.
- We saw evidence of daily cleaning records completed at the end of each working day which showed the scanning room floor and equipment within it were cleaned daily.

Good

Diagnostic imaging

- The waiting areas appeared to be clean, tidy, clean and clutter free. The waiting room chairs were wipeable.

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 clinic consisted of a staffed reception desk and waiting area. This was wheelchair accessible. There was comfortable seating with tea and coffee making facilities available, a water dispenser, magazines and a television mounted on the wall.
- Entry to the scanning area was secure. There was swipe access with a key fob for staff.
- Appropriate safety information was displayed on the door from the reception area to the scanning room and on the scanning room door.
- There were fire safety signs and fire extinguishers were accessible. MRI safety signs and 'no pacemaker' signs were visible.
- Most equipment we viewed conformed to relevant safety standards and was serviced on a regular basis. We saw that electrical equipment was safety tested. Staff carried out daily quality assurance checks on the scanners to ensure they performed safely.
- During inspection we found two fire extinguishers stored outside the MRI scan room labelled with manufacturer non specific labelling. The service did not adhere to MHRA specific guidance surrounding the labelling of equipment for example; MR safe, MR unsafe and MR conditional. We were assured by the provider that this has been rectified since inspection. Procurement and application of MR safe and MR unsafe stickers on fire extinguishers stored outside the MRI control room had been implemented.
- The MHRA recommends that all equipment that may be taken into the MR environment is clearly labelled using these markings and where possible, the appropriate descriptive text should be used.
- We saw evidence that magnetic resonance imaging compatible equipment was situated in the scan room. All relevant equipment within the scan room was labelled in line with MHRA recommendations being labelled magnetic resonance (MR) safe.
- In the magnetic resonance imaging area there was a scanning room and staff area for reporting which had a window allowing staff to see into the scanning room.
- There were two changing rooms available should a service user need to change into a gown and personal lockers for service users to use. There was a poster displayed reminding service users to remove all valuable items including metal jewellery, body piercings and coins.
- There was a unisex accessible toilet which service users in wheelchairs could use.
- During scanning all service users had access to an emergency call buzzer. Ear defenders were available with disposable covers and changed in between service users. A microphone allowed contact between the radiographer and the service user.
- There was an emergency eye wash station, oxygen, suction, a hand sanitiser gel dispenser located on the wall immediately outside the entry door to the scan room. There were also lockable boxes for service user valuables.
- Several different consumable items were checked, and all were found to be in date. Staff told us they had appropriate equipment to carry out their work and we found that there was a system in place to ensure appropriate stock levels and regular top up.
- We saw evidence of building evacuation plans. Evacuation routes were kept clear. All staff undertook fire safety training. There were an appropriate number of fire wardens available at the site. All fire exits were clearly marked, and fire alarms were regularly checked.
- During inspection we saw phantoms were used daily in the quality assurance process before any scans were undertaken and were stored in a locked cupboard. A phantom is a specially designed object

that is scanned or imaged in the field of medical imaging to evaluate, analyse, and tune the performance of various imaging devices including magnetic resonance imaging scanners.

- The upright MRI scanner was designed with the claustrophobic and anxious service user in mind. Service users could walk into the scanner. Service users could be scanned in the sitting position, lie slightly backward, lie horizontally or even stand in some cases dependant on what body part required scanning.
- Throughout the scan the service user could see the radiographers who were performing the scan and service users could watch television. We observed a service user undergoing a scan at the time of inspection and observed the differing positioning options available to service users. The service user was asked throughout the procedure to ensure that they were comfortable.
- The service user could be removed from the scanner quickly in the event of a clinical emergency.
- The service had a resuscitation trolley, all equipment on the trolley was checked and seen to be in date.
- There was a service level agreement contract which included repairs for the scanner. The scanner was serviced every six months. We saw evidence the service records were held electronically, and the last service had been carried out in September 2019.
- We observed on inspection that the service did not adhere to MHRA best practice following contractual servicing of machinery, fault repair or QA checks. The service did not use staff hand over forms following servicing and or repair of machinery to evidence quality assurance. We were assured by the provider that this has been rectified since inspection. The service has implemented a process to ensure that equipment hand over forms following service/repair by external providers are completed by Inhealth staff to evidence an audit trail.

Assessing and responding to service user risk

- Staff completed and updated risk assessments for each service user and removed or minimised risks. Staff identified and quickly acted upon service users at risk of deterioration.
- The service radiographers screened all referrals to ensure they were appropriate and all necessary information was on the referral form. Referral forms gave the service user clinical history, demographics, requested scan, referrer details and had ample space for the referrer to give any other relevant information. The safety forms covered implants, devices, metal fragments including in the eyes, pregnancy and recent or old surgery to head, eyes, ears and heart.
- We saw on inspection that the service had an acceptance criteria operating procedure in place. The Leeds Upright MRI Centre was a stand-alone MRI scanning centre and does not have the benefit of supporting facilities as in a hospital environment. To scan each service user successfully and safely, there were some restrictions which needed to be clarified before booking, to prevent any danger, a wasted journey, or unnecessary financial costs to the service user.
- Radiologists vetted all complex and contrast referrals.
- If the radiographer felt the referral was inappropriate or they needed further information they would contact the referrer directly. The radiographers were accountable for ensuring referrals were appropriate, determining if there were any contraindications and deciding if the scan should proceed.
- When a referral was accepted the radiographer or delegated member of staff would contact the service user to go through the MRI scanning safety checklist over the telephone. This ensured there were no contra-indications for the proposed scan and that service users were forewarned about the necessity of declaring any implants or foreign bodies that may be deemed a safety risk.
- A safety checklist form was given to the service user to fill in on arrival at the clinic to double check there were no reasons why the scan should not go ahead. The service user completed this form themselves as a self-declaration which doubled as a consent form. The safety checklist was discussed with the patient at the initial screening call to ensure that patients fully understood the risks associated with MRI imaging.
- Service users with certain risk factors could require a blood test to check kidney function prior to contrast

administration. There was a requirement the tests were carried out within three months of the scan. During inspection we saw documentary evidence of this process.

- The magnetic resonance imaging contrast safety form was sent out with the service user appointment forms to complete, sign and discuss with the radiographer when they attended their appointment.
- All service users were sent an information leaflet that included contraindications for an MRI scan which reinforced what had been discussed on the telephone.
- MRI scans were not undertaken during pregnancy.
- Administration staff double checked the information back to the service user to ensure understanding. Radiographers used a pause and check with the service user before entering the scan room.
- We saw that the service did not adhere to the InHealth service user identification policy which recommended a six-point pause and check. The pause and check included; service user, anatomy, user, system/settings, exposure and draw to close. We were assured by the provider that this has been rectified since inspection. The service had implemented a process requiring radiographers to sign and confirm a three-point identification check at point of handover in line with InHealth policy. An audit process had been implemented to evidence this process.
- During inspection we reviewed 10 clinical risk assessments all were in date and the information was current.
- We reviewed the InHealth administration of gadolinium-based contrast policy and the accompanying forms in relation to the administration of gadolinium which included a service user checklist. We also saw a copy of local work instruction service users requiring contrast during MRI issue six from March 2019 which provided staff with detailed information about the administration of contrast.
- An incident report would be completed for all incidents and near misses in the department. We saw evidence there was a process to record the outcome of any collapse of a service user while undergoing a scan which would be followed up by the most senior member of staff on duty.
- Staff told us if a service user deteriorated or collapsed all staff were trained to perform basic life support (BLS). They would act in accordance with their training. The service user would be removed from the scanning room until the blue light ambulance arrived and escorted them from the premises to hospital.
- Staff were trained in both adult and paediatric BLS. The service had a resuscitation policy date issued July 2018 due for review July 2019. The policy was designed to ensure staff were equipped and trained to offer the appropriate level of resuscitation support where this was required. We discussed the expired review date with the registered manager at the time of the inspection. InHealth had a policy and process in place to review all policy review dates which we saw on inspection. The policy highlighted was currently under review.
- The policy outlined the use of defibrillation, when appropriate, using an automated external defibrillator (AED) and the emergency call to “999” for a paramedic ambulance procedure. There was a procedure in place to ‘quench’ the magnet before entering the room to undertake emergency resuscitation.
- Following the scan all images were sent to the relevant picture archiving and communication system to ensure that they were available to the applicable clinical teams.
- In the 12 months prior to this inspection no service users had required to be transferred from the clinic to another health care provider before the scan had commenced.
- We saw evidence staff could obtain advice and support through the company’s network of retained medical and subject advisors who were accessible through the InHealth clinical quality team.

Staffing

- The service had enough staff with the right qualifications, skills, training and experience to keep service users safe from avoidable harm and to provide the right care and treatment.
- Staffing on the day we inspected met the actual planned staffing levels.

Good

Diagnostic imaging

- InHealth was committed to ensuring that every site operated a safe and effective service, with the appropriate number of staff and correct skill mix levels required to facilitate safe and compassionate care throughout the operational period. To meet this requirement, InHealth utilised a purpose built 'staffing calculator', designed to take account of expected, and a degree of unexpected, absences; ensuring sufficient staff availability across operational periods. This had been developed from years of experience of successfully running community diagnostic services and was proven to deliver the required full-time equivalent (FTE) clinical and non-clinical staffing complement for each location.
- Staff on part time contracts included an imaging services manager a senior radiographer, clinical assistant and a receptionist.
- The service did not have a designated children's nurse. The service only accepted children over the age of eight years old, and the referring clinician must be able to provide the service with a dedicated contact prior to acceptance of the referral.

Medical staffing

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Advice and support were provided through InHealth's extensive network of retained medical and subject matter expert advisors who are accessible through the clinical quality team.
- During scanning the radiographers had access to a radiologist to seek advice throughout InHealth. Should the radiographers observe an unexpected finding they ensured that a radiologist was able to view the scan that same day so that a report could be issued quickly. The service was drafting a local standard operating procedure (SOP) that was currently being written with assistance from a senior radiologist to ensure support was available.
- The service had contact telephone numbers of local radiologists that were held at reception should the service need to contact one of the radiologists urgently. The service also had the use of the other centres within InHealth and would contact them directly to make contact with their radiologists if required.
- Should the service require advice regarding any aspect of service user safety they had access to both the MRI clinical lead at InHealth who holds a magnetic resonance (MR) safety officer qualification and a magnetic resonance safety expert (MRSE) from InHealth, as well as the local MR responsible person, the imaging services manager.
- The service contracted three consultant musculoskeletal radiologists with practising privileges. The service also utilised the neuro reporting services of two radiologists based out of other centres.
- The service used radiologists based within the local NHS trust and from within InHealth group to review scan results and prepare reports for both NHS and private service users.
- There were no staff vacancies at the time of the inspection.
- The service did not use bank staff or agency staff because of the specialist nature of the service provided. In the event of staff calling in sick, InHealth staff from other base sites would cover the Leeds site as a priority.

Records

- Staff kept detailed records of service user care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.
- Magnetic resonance imaging referrals were mainly generated as electronic referrals through the InHealth group electronic system.
- Electronic referrals were reviewed on the orders list and were vetted by a consultant radiologist.
- Service user safety questionnaires were completed and reviewed for appropriateness for scanning.
- For service users with possible contraindications, any documented proof of compatibility was scanned into the electronic record system as evidence of decision making about safety.

Good

Diagnostic imaging

- When a service user arrived for a scan a radiographer went through the safety questionnaire confirming the answers and the consent before it was signed by the service user and radiographer. This information was scanned onto the InHealth service user recording systems.
- Once service users were scanned the images were transferred to the service user record system and reported. Reports were all electronically managed, the radiologist reported directly into InHealth cloud-based reporting radiology information system (RIS) system. This could be completed at any location the radiologist reported from or at home. The services primary reporting radiologist for the Leeds Centre attended the centre at least twice a month or more on reporting day to touch base and discuss issues and was available by phone if and when required.
- The reception team monitored the electronic diary looking for flagged pink reports that required sending as one of their first daily tasks. The reports wherever possible were sent via NHS.net email, another NHS.net email account to ensure security and adherence to data protection. Where this was not possible NHS.net email is used and [secure] typed into the subject bar. This ensured that the contents of the email are encrypted during transit and the recipient follows the instruction at their end to open the email.
- One further method of transfer that is often used is via the image exchange portal, where it can be transmitted with the images. It is the responsibility of the trust or person requesting to initiate this at their end, to flag with the service and be dealt with.
- If a report was urgent the reception team would contact the referrer to tell them that a report was being transferred to them urgently and allow them the option of how they wished to receive it.
- Service user safety questionnaires were completed and reviewed for appropriateness for scanning.
- Reports were sent via secure transfer methods within 48 hours.Printed copies of reports were only sent to the referring clinician if an alert was raised on the report or through the clinical information system. This ensured unexpected findings were escalated and actioned by the referrer.
- We saw evidence during inspection if a service user was to receive contrast their renal function was checked and recorded in the service user notes. A service users glomerular filtration rate (GFR) result would be accepted if it was within three months of the scan.

Medicines

- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service followed best practice when administering intravenous contrast media.
- Contrast media was administered under the direction of a consultant radiologist.
- Controlled drugs were not stored or administered as part of the services provided.
- The safe and secure management of medicines was overseen by the InHealth multidisciplinary 'Medicines Management Group' which met on a quarterly basis. Organisational pharmacist support and guidance was provided by In Health's retained pharmacy advisor.
- We reviewed the intravenous contrast storage. All the stock was kept in a locked cupboard in the magnetic resonance imaging room lobby. The stock was found to be in date.
- The registered manager told us if a service user required cannulation this was completed in the scan room. At the time of inspection, we did not observe the administration of contrast medium.
- Patient group directions (PGDs) were in place for all gadolinium-based contrast agents. PGDs were also in place for intravenous (IV) injections, saline and administration of oxygen. The PGD items were appropriately stored in a locked cupboard. There was evidence of daily stock checks. PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of service users, without them having to see a prescriber such as a doctor or nurse prescriber. PGD's were signed by staff to say that they had read & understood the PGD.
- The provider had a policy which required service user drug reactions to be reported. In addition, service users who had suffered a reaction had to be assessed

by the lead radiologist. A record of what had happened, and the action taken would be added to the service user notes. The incident would be reported to the Medicines and Healthcare products Regulatory Agency and on the service user electronic record, so staff were aware of the adverse reaction should the service user be admitted to hospital or require intervention from a general practitioner in the future.

- Any medicine related incidents were reported on a computer recording system and to the Medicines and Healthcare Products Regulatory Agency (MHRA).
- There had been no service user contrast reactions in the reporting period.

Incidents

- The service managed service user safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave service users honest information and suitable support. Managers ensured that actions from service user safety alerts were implemented and monitored.
- We saw evidence staff had been trained in using the adverse event and incident reporting systems. Staff were trained to report all near misses, adverse events and non-conformances promptly. These were reviewed weekly at the clinical governance meetings. Investigation and actions to address the adverse event would be recorded.
- The clinical governance team analysed data and identify themes and shared learning to prevent recurrence both at location and organisational level. Staff were aware of the importance of reporting near misses and incidents as a process to raise awareness of lessons learnt within the team as well as to identify any training needs which were required.
- The service had a system for the dissemination of rapid alerts. Alerts were sent out via email to all staff from the clinical governance team and MRI clinical lead for any issues surrounding medical devices or service user safety alerts.
- The service had an adverse event and incident reporting system. Staff were trained to report all near misses, adverse events and non-conformances promptly. These were reviewed weekly at the complaints, litigation, incidents and complaints (CLIC) meeting. Investigation and actions to address the adverse event were recorded. The clinical governance team analysed the data and identified themes and shared learning to prevent recurrence both at location and organisational level.
- The service also provided a monthly newsletter via CLIC (clinical governance) cascading health and safety information to staff. The registered manager printed all alerts and displayed these for staff in the centre to raise awareness.
- The service had reported no serious incidents between October 2018 and October 2019. Ten incidents had been reported with no harm included in this time frame. All the incidents had been risk assessed, risk rated, investigated, any learning shared and closed.
- Between October 2018 and October 2019, the service had not reported any never events. Never Events are service user safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers
- Staff we spoke with on inspection understood what duty of candour was and what their responsibilities were in relation to the duty of candour principles.
- Incidents involving service user harm were assessed against the 'notifiable safety incident 'criteria as defined within regulation 20 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. Incidents meeting this threshold would be managed under the organisation's 'adverse events (incident) reporting and management policy' and 'Duty of Candour, procedure for the notification of a notifiable safety incident' standard operating procedure.
- Decisions relating to organisational disclosures made both under the statutory duty of candour framework and in the wider spirit of openness and transparency if made would be recorded within the corresponding incident or complaint record and held within the electronic risk management system.

Good

Diagnostic imaging

Are diagnostic imaging services effective?

We do not currently rate the effective domain.

Evidence-based care and treatment

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- We saw evidence in service user notes and through speaking with staff that service users had their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice. This was done though the referral procedure and safety questionnaire.
- The service was supported by the clinical lead who held subject matter expertise in magnetic resonance imaging and produced evidence-based, best practice guidance in collaboration with the magnetic resonance safety expert.
- The guidance covered magnetic resonance imaging protocols, all aspects of magnetic resonance imaging safety and the establishment of the safety of implanted devices, management of claustrophobia and anxiety along with a suite of service user leaflets to meet the varying needs of service users including easy read, paediatric and large print.
- The service had developed local rules regarding MRI scanning and were in date. The local rules were comprehensive and in line with practice guidance such as the MHRA guideline: DB2007(03) 'Safety guidelines for Magnetic Resonance Imaging Equipment in Clinical Use'.
- Protocols were available for routine scan sequences and referral specific scans and were in line with current guidance. Protocols were authorised by consultant radiologists. The protocols were 'locked' into the scanner to ensure they could not be changed without authorisation and to ensure standardisation of the procedure and consistency of images.
- The resuscitation policy (V007) July 2019 had passed its review date. We were assured that there was a policy and process in place for the review of all corporate policies and observed the process during inspection.

Nutrition and hydration

- Service users were made aware of the length of time the MRI would possibly take. Tea, coffee and water facilities were available in the reception area.

Pain relief

- Staff assessed and monitored service users regularly to see if they were uncomfortable or in pain.
- Staff demonstrated they were aware that service users may be in pain and they ensured the scan caused as little discomfort as possible. Positioning aids were available if needed and staff checked on service user comfort via the intercom during the scan sequences.
- Staff gave an indication of the time the scan would take and checked that service users would be able to remain comfortable and still during the examination. Service users could alert staff if they were uncomfortable and needed the scan to stop.

Service user outcomes

- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The service did not provide a treatment to service users which enabled them to measure service user outcomes. However, the service did complete audits and quality assurance tests to ensure that they provided a service to measurable standards which they could monitor with the aim of making improvements.
- There was a quality assurance mechanism in place for peer reviewing MRI image quality and quality of reporting, which was 10% of all reports completed by those radiologists who reported at the centre in any given month. Should the number be less than 5, 100% of their reports would be audited.
- Peer review audit looked at 41% of images reported in October 2019 which were collated and sent to the

company's external auditors in November 2019. If there are any category one or two discrepancies, then these will be escalated to the service at the time of finding for further investigation.

- The peer review audit included 20 images and reported 100% of images were diagnostic. All images were of a high quality with no artefacts or discrepancies present.
- Once the scan had been completed, the images were sent for review by the consultant if any unexpected findings were identified.
- In the event of unexpected urgent clinical findings there was a clear process to follow. The consultant in session would be contacted and informed of the finding. They would then decide upon the next course of action.
- The registered manager told us that reports were turned around in most cases within 72 hours. Monthly audits from October 2018 to September 2019 showed that the range of turnaround time was from two to three days.
- The service collected service user feedback, audited waiting time from first contact to scan, turnaround times for reports and image and reporting quality audits.

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 monitor the effectiveness of the service.
- All MRI staff had undergone the company induction programme and a cannulation course, this meant a service user who may require cannulation could be cannulated in a timely manner.
- Staff told us advice could be obtained from the magnetic resonance imaging clinical lead by telephone.
- All staff had an annual appraisal plan where specific, measurable, achievable, reasonable, timely (SMART) objectives were set tailored to the individual and company's objectives. There was a mid-point review for staff to note how they were developing, and any further action required on both parts to meet the set objectives.
- We saw evidence that in the last 12 months all staff had received an appraisal, had their professional registration checked and had been revalidated.
- Staff were inducted and undertook an initial competency assessment followed by a mandatory training plan and role specific training to support ongoing competency and development.
- We reviewed the induction document given to new staff. The document contained essential information and referenced where to find information such as policies and procedures.
- During the induction period staff attended the InHealth company headquarters for training courses. In addition, staff members had a workbook with standards to complete. During the inspection we reviewed a workbook and saw evidence each standard when complete had been signed off by a supervisor. The member of staff`s progress was reviewed at four, eight and 12 weeks then annually. The purpose of the workbook was to gather a portfolio of evidence to progress to, obtaining a post graduate certificate in magnetic resonance imaging.
- Assurance of staff competence to perform their role within InHealth was assessed as part of the recruitment process, at induction, through probation, and then ongoing as part of staff performance management during the appraisal and personal development processes.
- There was an InHealth team of society of radiographers accredited practice educators. Their role was to develop the next generation of radiographers. In the event of any aspect of staff competency falling short of the required standard, the practitioner's line manager was responsible for providing necessary support and guidance required to attain the relevant standard.
- Ongoing staff competence was managed through the performance review process, with clinical staff also

required to complete continuous professional development to meet their professional body requirements, which were produced and discussed during appraisal.

- We saw staff development was supported by use of local audit, complaints and incidents review, which highlighted potential failing areas where different staff members may have need support and development.
- Modality specific training was given by the magnetic resonance safety expert and magnetic resonance imaging clinical lead who held an international magnetic resonance safety officer certificate.
- If poor performance was identified there was a process to monitor and address it through an action plan.

Multidisciplinary working

- Staff of different kinds worked together as a team to benefit service users.
- We saw that the team included, managers, radiographers, administration staff and support workers who all worked well together to provide a high-quality service.
- Members of the team communicated well with each other and gave examples of when they had liaised with referring clinicians and or the reporting consultants to address any queries or to provide or obtain any necessary information regarding the service user pathway.
- The service encouraged feedback and was open to feedback from staff, service users and referrers to ensure information and images provided were of a good quality and the service was effective for service users and met the needs of the referrers.
- The service undertook a weekly multidisciplinary complaints, litigation, incidents and compliments meeting to ensure that complaints were robustly investigated, and learning was shared throughout the business in a timely way.

Seven-day services

- Key services were available five days a week to support timely care.

Access to information

- Staff always had access to up-to-date, accurate and comprehensive information on service user care and treatment. All staff had access to an electronic records system that they could all update.
- We saw evidence all the information needed to deliver effective care and treatment was available to staff in a timely and accessible way. This included service user care and risk assessments, care and treatment plans.

Consent and Mental Capacity Act

- Staff understood how and when to assess whether a service user had the capacity to make decisions about their care. They followed the service policy and procedures when a service user could not give consent.
- Staff understood their roles and responsibilities under the Mental Health Act (1983) and the Mental Capacity Act (2005). They knew how to support service users experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Staff were aware of the requirements relating to mental capacity and consent specifically for service users that did not have the capacity to consent and the process for seeking advice in relation to this.
- Staff were aware of the need to support service users living with cognitive decline, dementia, reduced mental capacity and / or learning disabilities. The service ensured consent was received for all service users on arrival and the environment was safe for them within magnetic resonance imaging safety limitations. No service user would be scanned if they were unable to complete the safety forms or there was not proxy consent.
- Staff we spoke with understood this group of service users needed time and explanation before a scan and explanation and instructions should be kept short and simple and repeated as necessary to check understanding. Service users could be accompanied by their carers or family members where possible subject to the person being safe to go into the scanner.
- For service users who potentially lacked capacity, staff were aware of the requirements relating to mental capacity and consent, although due to the nature of the scanner, service users must have a level of

compliancy to ensure that images were diagnostic and that the test performed was in the best interest of the service user. Advice was available via the relevant policies and staff engaged with the relevant medical professional referring the service user into the service.

Are diagnostic imaging services caring?

Good

We rated the caring domain as good.

Compassionate care

- People are respected and valued as individuals and are empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.
- Staff treated service users with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Feedback from people who use the service, those who are close to them and stakeholders was continually positive about the way staff treat people. People think that staff go the extra mile and their care and support exceeds their expectations.
- We observed that all staff were polite and courteous to service users from arriving at the department to when they left.
- All MRI staff understood service user engagement, effective communication, empathy and patience was essential in helping service users get through the scan procedure.
- The reception team were skilled at talking to service users over the phone and had a good understanding of how the radiographers undertake procedures, allowing them to put service users at ease should they have any questions during booking.
- Service users were shown to a changing cubicle to maintain privacy and dignity while changing for scans, where available. Privacy blinds were drawn when service users had to change in the scan room. Staff placed service user's belongings in individual lockers while the service user went into the scan room.
- Staff escorted service users to and from the treatment room if contrast was to be administered and treated service users with dignity and respect.
- We observed staff confirmed with service users that they could hear the radiographer before commencing the scan.
- Staff communicated with service users through the intercom to ensure they were as comfortable as possible during the procedure.
- Staff were encouraged and empowered to engage with service users and their relatives in a sensitive and empathic manner taking account of their individual needs.
- Throughout every stage of the service user journey, efforts were made to modify and adapt care to take account of individual preferences and needs. This commenced from the booking of an appointment where service users were offered the opportunity to select their preferred method of contact and booking.
- InHealth had undertaken extensive work in developing resources to support service users experiencing scan related anxiety including a video to support with claustrophobia.
- Staff told us that most service users were referred into the service due to claustrophobia and anxiety issues. They explained that staff were experienced in dealing with phobias and were able to demonstrate a high level of empathy with individual service users.
- The staff were highly skilled at recognising the techniques that work for a particular service user via their experience dealing with them on a day to day basis. We saw that staff were supportive and communicative throughout the duration of the scan.
- Staff told us that service users could demonstrate unusual behaviours when struggling with anxiety. The team explained that this was often a manifestation of fear and often a defensive or coping mechanism. We saw staff being empathetic, patient and caring, demonstrating a professional understanding.
- Staff engaged well with service users, and thoroughly explained each part of the scan right from the moment the service user entered the scan room as confidently as possible to put the service user at ease. This

allowed time to adjust to the MR environment. At each moment the radiographer checked to ensure that the service user understood what had been said and was given the opportunity to ask questions. The radiographers maintained good communication with the service user throughout the procedure, advising them of their progress and duration remaining, and the service user could see the radiographer working, assisting in maintaining compliance, and giving the additional assurance that they had not been left on their own.

- Staff ensured that the service user fully understood how they would get their results following the scan.
- Service users were offered the opportunity to provide feedback. Staff told us they aimed to ask every service user for feedback. Managers collated the information from service user feedback and shared the findings with staff, so improvements could be made.
- InHealth aimed to give every service user the opportunity to complete the NHS Friends and Family Test (FFT) and indicate their likelihood to recommend the service, there was also an opportunity to add free text comments on any positive or negative aspects. The FFT process used a paper-based form complete with QR code and URL so that service users may choose to complete it digitally on a personal device.
- The results were collated by an external provider and delivered to service managers via the InHealth intranet weekly and via a web-based dashboard accessible to all managers. Service managers reviewed the results which summarised response rates.
- The Leeds Upright MRI Centre had become part of InHealth in May 2019 so there was limited location data at the time of the inspection. Overall likelihood to recommend (currently 97%+) and unlikely to recommend (currently 1%). The free text comments were interrogated to enable positive staff feedback and individuals could be praised where they noted for the quality of care delivered. Negative comments were scrutinised for opportunities to drive improvement in the service which may include changes to premises, staff training or service user information.
- Prior to becoming part of InHealth, United Open MRI Ltd utilised service user feedback surveys and face book recommendations as well as receiving emails and cards from service users.

Emotional support

- Staff provided emotional support to service users, families and carers to minimise their distress. They understood the service user's personal, cultural and religious needs.
- Peoples emotional and social needs were seen as being as important as their physical needs.
- Service user feedback was positive about the service and staff. Staff were described as being friendly, caring and supportive and the service was described as being quick, professional, easy to access and efficient.
- Service users told us staff were helpful and understanding, informative, polite, calming, they gave timely updates, were reassuring and explained things well. One service user told us a staff member 'stayed with me the whole way through'. Another said, 'staff were caring and helpful before, during and after the scan'.
- Staff always discussed with the service user the reason for their procedure and any medical history the service user had given on admission. All information was documented on the service user pathway.
- All members of the team were introduced to the service user and told who would be looking after them throughout their time at the clinic.
- There was a chaperone poster stating the clinic could provide another member of staff to be present during the magnetic resonance imaging scan.

Understanding and involvement of service users and those close to them

- Staff empowered people who use the service to have a voice and to realise their potential. They show determination and creativity to overcome obstacles to delivering care. Peoples individual preferences and needs were reflected in how care was delivered.
- The vast majority of service users were extremely claustrophobic and or anxious, and many have had traumatic experiences when attempting traditional

supine MRI. As such, the service took all available steps to inform and reassure service users prior to their attendance. Service users were invited to visit the centre prior to their appointment to view the scanner and discuss any concerns with a radiographer. The service allowed additional time for service users who were particularly claustrophobic or anxious and encouraged all service users to bring a friend or relative with them who was welcome to accompany them for the duration of their scan following careful safety screening.

- Staff we spoke with understood fully the needs of service users and why they had attended for a scan including the impact that person's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially.
- People who used the service and those close to them were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person. Staff were able to find innovative ways to enable people to overcome anxiety and specific phobias.
- Staff gave examples of how they had adapted plans of care for service users with specific phobias. An example of this was made by offering out of hours appointment times and repeat visits at differing points in the service user journey to enable the service user to experience this part of their pathway prior to their appointment. The same staff facilitated this to establish rapport with the service user, provide continuity, support and assurance. Staff were able to facilitate a plan of care to manage and meet individual service user expectation.
- Staff empowered people who used the service to have a voice and to realise their potential. They showed creativity to overcome obstacles to delivering care. Peoples individual preferences and needs were reflected in how care was delivered. An example of this was made by offering individual appointments with named radiographers, supported by a relative/partner to offer continued support and assurance throughout the MRI procedure.
- The service could utilise a television by means of a distraction technique. Service user feedback evidenced how useful this was. The service used subtitles on the screen as a distraction technique.
- During inspection radiographers were observed communicating with service users over the scanner intercom providing reassurance and providing updates as to how long the scan would take.
- Staff were trained in equality and diversity and made great efforts to provide an individualised service to service users.

Are diagnostic imaging services responsive?

Good

We rated the responsive domain as good.

Service delivery to meet the needs of local people

- Staff involved service users and those close to them in decisions about their care and treatment.
- There were sufficient parking facilities for service users and staff.
- The service worked closely with commissioners and other service providers to provide an integrated service where it was needed most.
- The service provided a wide range of examinations in line with the current contractual requirements which included but not limited to musculoskeletal, head, spine and neurological magnetic resonance imaging scans.
- All NHS service users referred for magnetic resonance imaging had been reviewed by their referring clinician or referral team prior to attendance.
- Private self-referrals were only accepted if the service user was aged 18 and above and included contact details for the referring clinician. Where possible all service user reports were communicated with the GP or referring clinician via secure email.
- Service users requesting self-referral were advised that they were required to complete a self-referral form,

detailing the reasons why they wished to have a scan. If it was for a medical complaint, this should be self-documented. If it was for reassurance, this should be stated.

Meeting people's individual needs

- The service was inclusive and took account service users individual needs and preferences. Staff made reasonable adjustments to help service user's access services. They coordinated care with other services and providers.
- The upright scanner gave individual service users differing options including screening for service users with claustrophobia and anxiety having a greater likelihood of completing the scan without sedation. The scanner assisted service users who were larger and found it hard to fit into the constricted space of a conventional scanner, service users who were unable to lie supine whatever the reason and service users who needed to be observed during their scan.
- Easy to read leaflets and large print information leaflets were available and braille could be provided on request.
- Staff understood service users may feel distressed because they may have needed to undress and change into a gown which could have made the service user feel vulnerable. A chaperone would be provided if requested by the service user to provide reassurance.
- Staff recognised service users may have experienced claustrophobia or the sense of anxiety which can be distressing. A section of the radiographer's clinical competency assessment covered claustrophobia, how to recognise it and how to help a service user manage it during their scan.
- The service provided imaging for service users aged eight years and over.
- The unit was accessible to service users with limited mobility. The unit was located at floor level from the main entrance to the building, so it was accessible for wheelchairs and trolleys.
- In the unit there was a magnetic resonance imaging compatible wheelchair available should the service user be unable to weight bear or walk into the scanner room.
- Language line interpreters could be sourced if the service was informed prior to the service user arriving on site. In a clinical emergency, InHealth policy enabled staff to use the language line, interpreting service if required.
- In relation to children, staff understood it could be a stressful time for parents. Staff ensured parents were well informed about the procedure and they could stay with their child throughout the scan subject to MRI scanner safety screening.
- Requests for a scan or diagnostic procedure referrals were followed up by a pre-assessment questionnaire asking the individual to identify if they had any conditions including allergies preventing them from undergoing a scan or procedure. We saw evidence of this on electronic referral forms.
- InHealth is an early independent sector adopter of NHS England's 'Always Events' methodology and worked with service users to co design services and information resources to meet their individual needs.

Access and flow

- People could access the service when they needed it and received the right care in a timely way.
- The service offered an appointment-based service, service users could self-refer and choose appointment slots to suit their individual needs.
- Activity differed on a day to day basis, ranging from an average of seven service users per day down to as low as two or three on less busy days.
- In the reporting period from October 2018 to September 2019, 549 service users attended the service for MRI scans, around 55% scans were NHS funded and around 45% were self-funded. One child (NHS contract) was scanned during this timeframe.
- During inspection we saw evidence of monthly audits of waiting times. In the reporting period of September 2019, the service had performed 47 MRI scans, with a total of 19 delays. The delays listed ranged from;

unable to contact the service user, appointment at service user request and funding delays. The service monitored delays in order to ensure delays did not impact upon availability of treatment time.

Learning from complaints and concerns

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- In the reporting period from October 2018 to October 2019 the service had received one complaint. The complaint was managed in accordance with InHealth complaints policy.
- There were complaint forms available for service users in the scanning room area which outlined how to make a compliant.
- Staff we spoke with told us if service users, relatives or carers raised an issue with them they would try to resolve it immediately. If they could not, they would encourage them to raise any concerns or issues with the most senior member of staff on duty or the person in charge of the unit in the first instance.
- Staff were empowered to attempt to resolve concerns locally wherever possible. Where a service user or relative chose to raise a 'formal' complaint, information leaflets explaining the process were available. Escalation pathways were available in each location where services were provided.
- There was a process for formal complaints to be logged and recorded using the organisation's electronic risk management system. InHealth aimed to acknowledge all complaints within three working days and investigate and formally respond within 20 working days.
- InHealth operated a three stage complaints management policy; stage one was local resolution, which was an investigation and response coordinated by the local service CQC registered manager, stage two was an internal director review, and stage three was an external independent review. An external review was provided by either the Parliamentary Health Service Ombudsman for NHS funded service users or Independent Healthcare Sector Complaints Adjudication Service (ISCAS) for privately funded service users.

Are diagnostic imaging services well-led?

Good

We rated the well led domain as good.

Leadership

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- The regional management consisted of a director of operations north, a head of imaging services north and an operational manager who was also the registered manager and responsible for the other InHealth scan sites in the region.
- The management team were described as approachable, open and honest. The unit was described by staff we spoke with as, "a lovely environment to work in conducive to learning and progression.
- The unit and the operational manager were supported by the regional InHealth head of imaging services.
- The management team were described as approachable, open and honest.
- InHealth group had invested heavily in its leaders empowering them to take accountability and responsibility for the service provided within their areas of responsibility. This commitment included the provision of a bespoke leadership and development programme for first line operational and service managers.
- A strong operational management and central governance structure provided support and guidance in all aspects of service delivery. Staff were encouraged to provide feedback to the business through an annual staff survey which was used to develop service plans at both an organisational and service level. The executive team regularly scrutinised quality data from all services through the monthly reporting structure and used this information to inform service development and workforce planning.
- InHealth operated a robust clinical and operational governance framework to ensure a high quality of

service was provided. Local service leadership was provided by a CQC registered manager and was supported by experienced clinicians and administrative teams.

- Staff were empowered to take accountability for the services they provided and were supported to grow and develop ideas and practices to improve service users and organisational safety.
- InHealth evidenced 'board to floor' awareness of issues and safety concerns were achieved through a comprehensive programme of governance committees and working groups led by the risk and governance committee.
- InHealth as a group had held the investors in people (IIP) gold award since 2013, which is an external recognition of excellent people management and development approaches. IIP accreditation required significant and ongoing investment, InHealth as a group had reviewed people-related activities and believed that the funding requirements for IIP could be better used elsewhere.
- The registered manager told us that InHealth would not be renewing their IIP accreditation in December 2019. They intended to focus funding efforts on a range of people-focussed activity, including; management and leadership development, clinical development, staff survey divisional and departmental action plans, Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) action plans, wellbeing and mental health, rewards and recognition and improving the digital experience.
- Post inspection we were advised that the IIP accreditation would end in December 2019, when all public references to IIP would be removed from the website, and April 2020 when all IIP references on internal materials would be removed.

Vision and strategy

- The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, service users, and local community groups.
- InHealth had four core values: Care, Trust, Passion and Fresh thinking and a company mission to 'Make Healthcare Better' the aim of which was to enable all employees to offer a fresh, innovative approach to the care delivered. All staff were introduced to these core values at the corporate induction and these were linked to staff appraisals.
- The service had a mission statement on their internet page which is, to make healthcare better, which would be achieved by working with hospitals and commissioners across the NHS and independent sector.
- The internet page also outlined the primary goal of the service which was to make healthcare better by providing rapid and accurate assessment of every service users condition, enabling the right treatment to be delivered swiftly and effectively by specialist providers.
- The core values were displayed on the MRI office wall.
- The service had developed a clinical quality strategy (CQS). The clinical quality subcommittee (CQSC) carried out a strengths, weaknesses, opportunities and threats (SWOT) analysis to inform the programme to 2020 and to ensure that the service continued to meet strategic objectives. Analysis of the action areas showed that the opportunities for continuous quality improvement fell into four main themes: improve audit and monitoring, improve clinical practice and management, improve communications and engagement with service users and staff and support the development of services.
- Staff said they felt supported and that the leaders were approachable, they gave examples of being supported with training and development and told us their ideas were listened to and acted upon in discussion with the team.

Culture

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- There appeared to be an open culture where there was an emphasis on collaborative working, a desire to continuously improve and shared learning.

Good

Diagnostic imaging

- During the inspection staff told us they felt part of a team and everyone supported each other. Staff told us they felt valued, listened to, supported and that training and development was encouraged.
- We observed good team work and support during the inspection.
- Staff we spoke with told us the quality of the scan was more important than the quantity of scans completed.
- The staff we spoke were very positive about the department. They told us they felt service user care was excellent and the ability to turnaround scan reports quickly was part of that. They all spoke about good communication between staff and positive management support to obtain additional training qualifications.
- Staff told us they felt they could raise any issues with their supervisors and they were able to maintain a good work life balance.
- Policies and procedures were in place to guide staff practice and expected behaviours. Policies indicated that any issues, where staff acted outside of policy or displayed inappropriate behaviours, would be taken seriously and dealt with appropriately.
- Although staff were unable to give examples of occasions when they had to raise concerns about staff practice issues this responsibility was clearly understood. There was a freedom to speak up to support staff with this course of action if required.

Governance

- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.
- InHealth operated a comprehensive clinical governance framework to assure the quality of services provided. Quality monitoring was the responsibility of the location registered manager. This was supported through the InHealth clinical quality team via the clinical governance framework and governance committee structure and led by the director of clinical quality.
- The service contracted three consultant musculoskeletal radiologists with practising privileges.
- This included the quarterly risk and governance committee, clinical quality sub-committee, medicines management group, water safety group, management of doctors group, radiation protection group, magnetic resonance safety and quality group, radiology reporting group and the weekly CLIC meeting for review of incidents and identification of shared learning. All these meetings had a standard agenda and outputs which included minutes and action logs. This ensured that actions to improve were recorded and monitored for completion to ensure a continuous improvement cycle.
- There was a system of risk assessments in place and risks with higher scores were added to the local risk register. Those with high post mitigation scores were added to the regional risk register. A quarterly report on new and updated risks was sent to the quarterly risk and governance committee where it was reviewed for comment and action as necessary. Support with risk assessments was provided by the health and safety advisor and the risk and governance lead who also advised registered managers on the correct process to add a risk to the risk register and completed the quarterly risk report.
- Quality monitoring was the responsibility of the location registered manager and was supported through the InHealth clinical quality team via the clinical governance framework and governance committee structure led by the director of clinical quality.
- We saw evidence of identified leads in governance and regulatory roles within the service which detailed how staff could contact them for advice.
- The service had reported 10 incidents between May 2019 and September 2019. The incidents were; three clinical safety incidents with no harm, two booking incidents, three breach of confidentiality incidents and two other incidents which did not fall into the other categories. All incidents had been risk assessed, risk rated, investigated, any learning shared and closed.

Managing risks, issues and performance

- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

- We saw evidence risks were assessed and recorded and where applicable recorded on the risk register and escalated to senior managers.
- There was a system of risk assessments in place and risks with higher scores were added to the local risk register. Those with high post mitigation scores were added to the regional risk register.
- Risk assessments were conducted regularly for all areas of the service and covered areas such as fire hazards, trip hazards, equipment safety and electrical safety.
- We saw evidence the local risk register was reviewed monthly and included an action plan to track progress on any current local issues or identified risks.
- Copies of the local risk registers were saved to the company intranet for review by the regional director of imaging services. Any immediate concerns were raised with the head of imaging services once identified and escalated concerns were reviewed and considered for the functional and corporate risk registers.
- Known risks with high post mitigation scores were added to the regional risk register. A quarterly report on new and updated risks was sent to the quarterly risk and governance committee where it is reviewed for comment and action as necessary.
- Support with risk assessments was provided by the health and safety advisor and the risk and governance lead who also advised registered managers on the correct process to add a risk to the risk register and complete the quarterly risk report.
- There was evidence service user risk was discussed at the clinical quality team meetings.
- Evacuation plans were available and evacuation routes kept clear. All staff had undertaken fire safety training. There are an appropriate number of fire wardens available at the site. All fire exits were clearly marked, and fire alarms are regularly checked.
- The service had a current ISO/IEC 270001 certificate of approval. ISO/IEC 270001 specifies a management system that is intended to bring information security under management control and gives specific requirements. Organisations that meet the requirements may be certified by an accredited certification body following successful completion of an audit.

Managing information

- The service collected, analysed, managed and used information well to support its activities, using secure electronic systems with security safeguards.
- All staff had undergone information governance training and we saw that the recent changes to General Data Protection Regulation (GDPR) had been considered and discussed.
- There were systems and processes in place to maintain security of information including service user records. There were minimal paper records for service users and these were scanned on to an electronic system for retention and destroyed at the end of an episode of care.
- Minimal paper records were stored on the premises. A daily minimal record of service user details was stored on site in the event of information technology failure. These records were stored in a locked filing cabinet and destroyed following service user treatment.
- The service had employed a service to test their IT systems to check the security of file transfers and general security of the systems. The IT system had been assured as secure.

Engagement

- The service engaged with service users, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- InHealth provided every service user the opportunity to complete the NHS friends and family test and indicate their likelihood to recommend the service. There was also an opportunity to add free text comments on any positive or negative aspects.
- The results were collated by an external company and delivered to service managers via the InHealth intranet weekly and via a web-based dashboard accessible to

all managers. Service managers reviewed the results which summarised response rates. Overall likelihood to recommend was currently 97% and unlikely to recommend was currently 1%.

- The free text comments were interrogated to enable positive staff feedback and individuals could be praised. Negative comments were scrutinised for opportunities to drive improvement in the service which included changes to premises, staff training or service user information.
- Since 2016 the service had been allowing service users to take more control of their care and allow them to directly self-refer for an MRI scan in response to enquiries of this nature across all the United open MRI Ltd centres. These were carefully monitored and scrutinised by the radiographic team to ensure that they fulfilled the criteria set out in the services inclusion criteria and there was a policy to support this.
- Comments including compliments and any learning opportunities were shared to encourage staff to continually improve the service user experience.
- Staff satisfaction surveys were undertaken annually to seek views of all employees within the organisation and actions plans implemented from the feedback received.
- The service was introducing a new staff partnership forum as an opportunity for information sharing and consultation between InHealth and their employees on collective employment related matters.

Learning, continuous improvement and innovation

- Since becoming part of InHealth in May 2019 the Leeds Upright MRI Centre had undergone rapid improvement with regard to both its governance and management structure. In addition to this the service had a large team behind them to help drive the centre to ensure delivery of the best possible service to service users.
- The service was in the process of drafting a new travel questionnaire and gaining feedback on the service's current map issued to service users. The service intended to improve the service user experience by finding better ways of guiding service users to the centre. The centre was housed in a listed building which impacted on the use of signage on the outside of the building.
- Further plans were in progress to improve the look and feel of the scan room for service users.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve
Action the provider SHOULD take to improve

- The service should monitor, and audit completion of hand over forms following contractual servicing and or repair of machinery to ensure processes are embedded and robust.
- The service should monitor, and audit standard labelling of equipment in line with MHRA best practice for example; MR safe, MR unsafe and MR conditional to ensure processes are embedded and robust.