Beechwood Hall

Quality Report

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

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Not sufficient evidence to rate ●
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

Overall summary

Beechwood Hall is operated by InHealth Limited. Beechwood Hall provides a country wide mobile service. Services are provided in a range of locations including mobile units, stand-alone diagnostic centres or within rented rooms within community or hospital healthcare sites.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection at the providers head office on 4 February 2020, along with unannounced inspections of six different types of diagnostic services between 4 and 14 February 2020, across 21 sites country wide.

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

Summary of findings

as outstanding, good, requires improvement or inadequate. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

We rated this service as **Outstanding** overall as we found many areas of outstanding practice:

- The nature of the service being provided out of small clinics and mobile units meant the service was very flexible. The focus was on providing patients with a service that meant they had choice as to dates, times and locations of services.
- The culture of the organisation was focused on the patient experience and how to provide outstanding care. We saw numerous examples of staff going 'above and beyond' which we have detailed within the report.
- Staff working in Magnetic Resonance Imaging had completed a large project in conjunction with a patient network group to use the eight C's of caring; consider, compassion, comfort, confidence, communication, control, calming and change, to better understand patient anxiety in relation to scans and make changes to practice as a result of these findings.
- Abdominal Aortic Aneurysm screening staff provided services at residential and nursing homes to support patients with difficulties getting to a clinic. This was to support older men, the group of patients most likely to suffer an aneurysm.
- Staff worked with learning disability nurses to promote the importance of breast screening for patients with learning disabilities. This was after a project found that health screening for patients focused on their learning disability rather than other possible co-morbidities.
- The strong culture of improvement and innovation from the managerial team allowed staff to develop their skills and the service to improve.

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

Nigel Acheson Deputy Chief Inspector of Hospitals (London and South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	**Outstanding** ☆	The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. Services were tailored to meet the needs of individuals and were delivered in a way to ensure flexibility, choice and continuity of care. Individual needs and preferences were central to the planning and delivery of tailored services The leadership, governance and culture were used to drive and improve the delivery of high- quality person-centred care. Governance and performance management arrangements were proactively reviewed and reflected best practice.

Summary of findings

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Outstanding ☆

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Summary of this inspection

Background to Beechwood Hall

Beechwood Hall is operated by InHealth Limited. The service opened in 2011. Its head office is located in High Wycombe, Buckinghamshire. The service has one nominated individual with 12 registered managers responsible for different types of screening and managerial support.

The service works within both the NHS and private sector to provide mobile diagnostic imaging services. At the time of inspection, Beechwood Hall operated from 300 locations across the UK and served 3 million patients each year.

Beechwood Hall provides both direct access and host organisation diagnostic support services from either mobile or fixed community and acute locations. It manages either end to end patient pathways or individual aspects of care to suit the needs of commissioning organisations.

The report references individual sites as specific examples, however these have been corroborated across all sites inspected.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, CQC inspection manager, nine other CQC inspectors, and three specialist advisors with expertise in radiography. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Information about Beechwood Hall

The service is registered to provide the following regulated activities:

- Treatment of Disease, Disorder or Injury
- Surgical Procedures
- Diagnostic and Screening Procedures

We inspected six different diagnostic imaging services under the umbrella of diagnostic imaging, these were:

Dual energy x-ray absorptiometry (DEXA). Uses low dose x-rays to take measurements to work out the strength (density) of your bones.

Positron emission tomography – computed tomography (PET CT) is a nuclear medicine technique which combines, in a single gantry, a positron emission tomography scanner and an x-ray computed tomography scanner.

Ultrasound - Sound waves with frequencies higher than the upper audible limit of human hearing. Ultrasound is not different from "normal" sound in its physical properties, except that humans cannot hear it. Ultrasound waves are applied to the area of interest in order to create an image or scan picture.

Computed tomography (CT) scan makes use of computer-processed combinations of many X-ray measurements taken from different angles to produce cross-sectional images of specific areas of a scanned object.

Magnetic resonance imaging (MRI) medical imaging technique used in radiology to form pictures of the anatomy and the physiological processes of the body. MRI scanners use strong magnetic fields, magnetic field gradients, and radio waves to generate images of the organs in the body.

Abdominal aortic aneurysm (AAA) screening is a way of checking if there's a bulge or swelling in the aorta, the main blood vessel that runs from your heart down

Summary of this inspection

through the stomach. Results showing a diameter of 3.0cm or over indicate that there is an AAA. Measurements of 5.5cm or over meet the threshold for treatment and are referred for surgical review.

This service also provides audiology and cardiovascular screening. We spoke with managers of these services, however did not inspect them as they are outside of the scope of CQC regulation.

We inspected mobile units, community and acute locations. We spoke with 60 staff including radiographers, sonographers, assistants and managers. We spoke with 30 patients. There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

Activity (Mid November 2018 to Mid November 2019):

- At the time of inspection, Beechwood Hall had contracts with over 13 NHS commissioners.

Track record on safety:

- No Never events
- Two serious incidents
- One IRMER/IRR reportable incidents (at the time of inspection the investigation was not complete)
- 380 complaints

Services accredited by a national body:

- ISO 9001: 2015
- ISO 27001: 2013

Outsourced services:

- Clinical auditing and reporting
- Cleaning services
- Water testing
- Medical and clinical waste management
- Radioisotope provision
- Medical Physics Expert
- Radiation Protection Advisor
- MR Safety Expert
- Vascular Nurse Practitioner

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 it as Good because:

There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse.

Staff received up-to-date training in all safety systems. Staff took a proactive approach to safeguarding.

Staffing levels and skill mix are planned, implemented and reviewed to keep patients safe at all times.

Staff recognised and responded appropriately to changes in risks to people who used services.

Are services effective?

Not sufficient evidence to rate

We currently do not rate effective for diagnostic imaging. However, we found:

Patients' care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.

There was participation in relevant local and national audits.

Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice.

Are services caring?

Outstanding

We rated it as Outstanding because:

Feedback from patients who used the service, those who are close to them and stakeholders was continually positive about the way staff treated people. Patient's thought staff went the extra mile and the care they received exceeded their expectations.

There was a strong, visible person-centred culture. Staff were motivated to offer care that was kind and promotes people's dignity.

Staff recognised and respected patient's needs and always took patient's personal, cultural, social and religious needs into account.

Staff were fully committed to working in partnership with patients and individual preferences and needs were always reflected in how care is delivered.

Patients emotional and social needs were embedded in their care and treatment.

Summary of this inspection

Are services responsive?

Outstanding 

We rated it as Outstanding because:

People's individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, provided choice and ensured continuity of care.

The involvement of other organizations' and the local community was integral to how services were planned and ensured that services met people's needs.

There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs and promoted equality. This included patients with complex needs.

Patients could access services in a way and at a time that suited them.

There was active review of complaints and how they were managed and responded to, and improvements were made as a result across the service.

Are services well-led?

Outstanding 

We rated it as Outstanding because:

Leaders had a shared purpose, strove to deliver and motivate staff to succeed. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture. Leadership was knowledgeable about quality issues. Managers had the experience, capacity and capability to ensure that the strategy could be delivered. Leaders encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported.

Governance and performance management arrangements were proactively reviewed and reflected best practice.

There was an effective and comprehensive process in place to identify, understand, monitor and address current and future risks.

There was a culture of collective responsibility between teams and services. The service proactively engaged and involved staff and ensured that the voices of staff were acted on.

Safe innovation was celebrated.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Not rated	Outstanding	Outstanding	Outstanding	Outstanding
Overall	Good	Not rated	Outstanding	Outstanding	Outstanding	Outstanding

Outstanding ☆

Diagnostic imaging

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

Are diagnostic imaging services safe?

Good

We rated this service as **good**.

Mandatory training

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

Mandatory training was provided via a combination of online and face to face courses. The completion rate for mandatory training was 90% in line with the providers target. Subjects included; health and safety, fire training and infection control.

Managers received a monthly report detailing staff completion of mandatory training. This ensured managers had time to book staff onto training before their expiration date. Staff advised us they received protected time to complete their mandatory training.

Specific training such as magnetic resonance imaging safety training was led by the providers Safety Expert and the MRI clinical lead. Radiation protection training was led by the Radiation Protection Advisor and a team of Radiation Protection Supervisors at location level.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff knew their role and responsibilities in keeping patients and families safe. All staff we spoke with could access the online safeguarding system and knew how to complete a referral form. Staff were also aware of their responsibilities in recognising and reporting of female genital mutilation.

The staff completion rate for safeguarding training was 90% across all services, in line with the providers target. Staff had completed safeguarding level two for adults and children. All staff we spoke with knew who the company safeguarding lead was, and that any concerns were to be reported to them. The safeguarding lead was trained to level four safeguarding in line with the intercollegiate document.

Staff in abdominal aortic aneurysm gave us examples of when they had made a safeguarding referral and described how the handling of the incident was shared and discussed at team meetings in order that staff could learn from a real-life example.

Managers monitored safeguarding referrals and compliance with safeguarding policies and procedures at a weekly meeting. Any changes or updates were reviewed regarding their effectiveness at the quarterly safeguarding monitoring meeting.

Cleanliness, infection control and hygiene

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

All mobile units and host hospital rooms we visited were visibly clean. Staff at all locations inspected followed daily cleaning check lists. These detailed which cleaning tasks needed to be completed and staff told us they filled in the check list when the task was completed.

Diagnostic imaging

Staff maintained good standards of hand hygiene. Staff accessed hand washing facilities at the host hospital and we saw staff washing their hands in line with World Health Organisation Five Moments for Hand Hygiene. We also saw staff using hand sanitiser gel as recommended. Staff at all sites were bare below the elbows in accordance with best practice, to help facilitate effective hand washing and reduce the risk of infection.

Personal protective equipment such as aprons and gloves were available and we observed staff used them during patient care. Gloves were available in different sizes in accordance with Health and Safety Executive guidelines.

Where a clinic was held in a host hospital, it was the hospitals responsibility to ensure the cleanliness of the room. This was stipulated within the service level agreement. We saw staff check with on-site housekeeping that clinic rooms were clean as part of their daily checks.

We saw staff clean equipment between patients and staff used sterile probe covers where appropriate.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe.

Each site had its own set of safety protocols designed for the specific environment and facilities available on site. These were reviewed monthly and signed off by managers. Staff advised us a mobile unit was relocated within a hospital car park the day after the monthly review. This was because the pavement where it was previously located had become uneven and a trip hazard. We saw the quality assurance programme which included mobile unit servicing and a plan for replacing old equipment and mobile units. The provider was on track for the 2020 replacement programme including x-ray equipment and documents showed all mobile units had been serviced within the last 12 months. Access to services including electricity and water were agreed as part of the site set up assessment process and were detailed within the site plan.

At all locations we saw environmental daily and weekly check sheets. These were used by staff to check equipment was working, serviced and safe to use, for example defibrillator servicing and battery level, oxygen tank levels and servicing and helium tank servicing and levels were all checked daily as part of the unit daily checklist. Morning equipment checklists were specific for the days list. The end of day checks included, ensuring all stock was in date and ordering stock that was running low and ensuring all records had been sent.

Staff advised us when there was equipment failure, they reported it on the online incident system and that the planning team were quick to respond and either fix or replace faulty equipment. For example, staff at a CT unit in Rochdale advised us that two weeks prior to our inspection they lost internet connection and stated it was fixed within an hour and therefore did not impact on the clinic. Staff working on mobile units knew if they had an urgent problem with equipment to report the issue to the mobile planning team, their manager and the site manager. Senior staff met weekly to review reported equipment incidents and if necessary, find alternatives. For example, staff at an ultrasound clinic in Southampton advised us the scanner was new as it was more ergonomic than the previous one.

In MRI mobile units, all equipment outside of the scanning room was labelled MRI safe or unsafe. This helped to ensure staff did not accidentally take unsafe equipment into the scanning room. Equipment within mobile units could be secured to the floor to ensure it was safe during transit.

We checked consumables at all locations and found all were in date and in all MRI units we saw staff provided patients with ear plugs and ear protectors in line with Medicines and Healthcare Products Regulatory Agency guidelines.

The MRI mobile unit in Southampton was new and had a second exit that could be used in an emergency within the scan room. This meant staff could transport patients straight out of the unit, rather than bring them through the unit itself. Contaminated PET CT waste was stored on site in a specific area. Waste was kept on the unit until it was no longer radioactive and then disposed of in the host hospitals general waste. If the unit was required to move and the waste was still 'hot' there was a specific area for the hot waste to be stored in. When it had deactivated, it was InHealth's responsibility to remove it to the general waste.

Diagnostic imaging

All mobile MRI units did not have a barrier across the scanning room door. This was regardless of the age of the unit. The units were small and although there were warning signs on the door to the scanner not to enter, there was nothing to prevent someone, for example a relative, entering the scanner room.

Assessing and responding to patient risk

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

In all observed patient interactions, we saw staff ask patients to complete a safety questionnaire which was discussed after completion. All CQC staff were also asked to complete a safety questionnaire whilst on the units and in MRI units staff checked inspectors were not wearing metal items and were therefore safe to enter the magnetic MRI room.

Staff understood their role and responsibilities in accordance with As Low As Reasonably Achievable Principles, (a safety principle designed to minimise radiation doses). For example, a patient attended a CT scan in Plymouth, who had another CT scan six weeks prior. Staff questioned the patient as to the reason for the scan and whether they had seen their consultant following the first scan. When staff were happy with the rationale they went ahead with the scan. The rationale was documented on the patient record to show their justification for another scan in such a short space of time. This was in line with the above principals.

Staff carried out checks to ensure the right person gets the right scan following The Society and College of Radiographers 'Pause and Check' guidance system. We observed identification checks were completed in line with the guidance and there were posters to remind staff to do this.

We saw risk assessments were in place and were reviewed quarterly for the use of ionising radiation and the safe management of radionuclides. In PET and CT services staff followed daily site-specific risk assessments for ionising radiation. We saw these were fully completed and gave assurances that staff had checked, and minimised environmental risks associated with ionising radiation.

We saw local policies for the assessment and prevention of contrast-induced nephropathy (a form of kidney damage in which there has been recent exposure to medical imaging contrast material), which were in line with National Institute for Health and Care Excellence acute kidney injury guidelines as well as the Royal College of Radiologists standards for intravascular contrast agent administration.

At CT clinics, patients received a contrast medium to enhance the image, via an intravenous infusion, there was a risk of tissue damage if the infusion did not infuse correctly into the vein. To ensure prompt action was taken if this occurred staff monitored for signs of this occurring by monitoring the pressure of the infusion of contrast given via a catheter as well as visual checks of the infusion site. After the procedure patients were monitored for 15 to 20 minutes to ensure they did not suffer any adverse reactions. To facilitate this, staff at a CT clinic in Birmingham stated they did not conduct contrast scans during the last appointment of the day.

Emergency support varied from site to site. Each site risk assessment contained protocols and processes in the event a patient collapsed. Some mobile units were located in GP car parks, therefore they dialled 999 in the event of an emergency. Other units were located at large acute facilities, these locations had service level agreements with the host hospital regarding support and responsibilities in the event of a patient collapsing. If such an event occurred each member of staff was allocated a specific role. All staff we spoke with knew their responsibilities. At all locations staff had access to a defibrillator either on the mobile unit or at the host hospital. All staff we spoke with knew the location of their nearest defibrillator and this information was also included in the site assessment report. Records showed 90% of staff had completed either basic life support or immediate life support training. Staff told us about a recent incident where a patient attending an Abdominal aortic aneurysm clinic collapsed. Staff used the call bell to call for assistance, which was provided by the GP and called 999. All staff involved in the incident knew where to access oxygen, a defibrillator and manual suction.

The picture archiving communication system team flagged any patients that had been referred for an urgent scan. This ensured staff prioritised analysis of the patients imaging record.

Diagnostic imaging

To prevent unnecessary exposure of an unborn child to ionising radiation and in accordance with Royal College of Radiologists guidelines, all females between the ages of 12 and 50 and receiving a scan between the knees and the diaphragm were asked about the possibility of being pregnant. For MRI and CT scans this occurred during the booking in process. This was also discussed at initial assessment and again at the scan. In CT clinics we saw several posters notifying patients of the dangers of CT scans whilst pregnant.

Before staff administered pain relief injections at ultrasound pain clinics, they ensured patients had taken adequate time off work and had someone to take them home after the procedure, due to the side effects of the injections. This ensured patients were looked after in the period immediately after their injection.

Patients who had received a PET CT scan were advised about the risk of them being radioactive via written documentation at the booking process and verbally when they were discharged from the scanner. The document included information regarding how patients could reduce the risk to others during the period straight after the scan, for example, not to sit directly next to people on public transport.

Staff were able to tell us what on-site support systems were available in case of an incident or fire at each location. For example, mobile units and some static rooms had call bell systems, other sites used an emergency telephone line. Fire evacuation plans were in place for each location within the site risk assessment. Staff knew the contents of the site assessment for each location they worked at and their roles and responsibilities to patients in the event of a fire. Staff working within mobile units practised an emergency evacuation of the mobile units once a year. Managers advised us the evacuations were held on random dates, therefore we were not assured the practices were frequent enough to ensure all staff had participated as there was no record of who had completed a practice evacuation.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The planning team had responsibility for ensuring rotas were fully staffed. Rotas for all clinics were arranged four weeks in advance. To review the number of staff available versus the number required for upcoming clinics an in-house calculator was used. The calculator took into consideration; operational hours, patient complexity, environment, activity levels and training requirements. Staffing levels were reviewed at weekly meetings to discuss future risks, for example maternity leave and shortages due to sickness.

Mobile imaging staff worked three long days a week and could be sent to work at any InHealth location for the type of scan they provided across their region. Some clinics required a set amount of staff based on national guidelines, for example Abdominal aortic aneurysm clinics were staffed in accordance with Public Health England 'Abdominal Aortic Aneurysm Screening Programme Essential elements in providing an Abdominal aortic aneurysm screening and surveillance programme'. This states the grades, qualifications, responsibilities and staffing numbers required depending on the size of the clinic. We saw Abdominal aortic aneurysm clinics staffed in accordance with the programme and staff advised us they always had enough staff on-site.

The fleet team consisted of six full time and one part time staff to manage the fleet of 100 mobile units. Staff we spoke with in the fleet team advised that they felt adequately staffed and staff within clinics advised there were never issues in obtaining and relocating mobile units.

MRI staff in Winchester advised us that when they had one to ones, a third radiographer attended the clinic to support staff and ensure there was no lone working. Breaks were scheduled into the planned list to ensure staff were not lone working at any point during the day.

We reviewed the providers 'lone working' policy and risk assessment process. Staff knew its content and how to access it. Each site also had a business continuity plan that detailed mitigation plans in the event of unexpected staff shortages.

Diagnostic imaging

We were advised the "Goal is to operate without the need for bank or agency staff." At the time of inspection there were no bank or agency staff working. We saw there was an induction pack in the event bank or agency staff were required. It contained information on; corporate induction, manual handling, fire safety, and responsibilities under the mental capacity act.

Records

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

Patient reports from clinics held on mobile units, post examination information and patient records were returned to the host hospital for amalgamation into the patient's clinical records. At some locations the host site provided staff with a computer to allow them to enter data directly onto the local information system, providing real time data input of examination details. Additional data was stored and managed on the providers clinical information system. Patient images were sent electronically via a data connection to the host site patient archiving communication system. The host site monitored the transfer and alerted staff if the data was incomplete.

Staff transmitted scan images to InHealth's secure patient archiving communication system. There was a separate archiving team who collated the images with the referral form and sent them securely to the appropriate third party, normally a GP.

An external auditor audited 10% of all reports on a monthly basis. Results were sent to senior managers, and any discrepancies fed back to the radiologist concerned, reported on the incident management system and investigated by the risk and governance lead.

Most locations inspected had access to an internet connection. However, some mobile units were located too far away from the main building to gain internet access, for example, the CT clinic at Beaumont, at these locations images were scanned onto disks and taken to the main hospital to be added to the hospitals main system. We asked how the team were sure the system was secure. Staff advised us the system used was the same as the NHS hospital and that third party systems were reviewed as part of the monthly site review.

At an ultrasound clinic in Southampton, the booking team noted a patient had a GP appointment the following day to discuss the results from the scan. Therefore, the results were to be sent as a matter of urgency. Staff sent the images immediately after the scan and called the GP at the end of clinic to ensure they had been received.

Medicines

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

Medicine compliance was reviewed at the 'Medicines Management Group' which met on a quarterly basis to ensure that all staff were working in accordance with the most up to date guidance and legislation.

Organisational pharmacist support and guidance was provided by the host hospitals pharmacy advisor. We saw in clinics where medicines were administered, local agreements with the host trust were in place for the supply, storage and use of medicines. Where required, we saw the ambient room temperature was regularly monitored which ensured the efficacy of medicines. Medicines were transported to mobile units on the day of the clinic and returned to the on-site trust at the end of the day. Medicines were not held on the mobile unit when they were non-operational. Radiologists held appropriate certificates for the administration of radioactive medicinal products and we saw where patients received medicines and/or intravenous contrast medium, allergies were clearly documented in the patient record.

Patient Group Directions (PGDs) provide a legal framework that allows some registered health professionals to supply and/or administer medicines, without them having to see a prescriber (such as a doctor or nurse prescriber). Patient group directions were in place at Beechwood Hall. Their use was agreed at each location where staff were approved to use them by the relevant department manager.

Sharps bins were signed, dated, secured and not filled above the fill line in accordance with Health and Safety Executive 'Health and Safety (Sharp Instruments in Healthcare) Regulations 2013'. Beechwood Hall had a service level agreement with on-site hospitals for the destruction of sharps.

Outstanding ☆

Diagnostic imaging

At a PET CT clinic in London, we saw the delivery of radioactive isotopes. Upon delivery, staff and the delivery team signed off on the medicine after checking correct doses had been delivered. We saw this was stored in a lead box until used in accordance with Department for Environment 'Scope of and exemptions from the radioactive substances legislation in England, Wales and Northern Ireland' guidance document 2018.

Incidents

The service managed patient 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 patients honest information and suitable support.

Incidents and near misses were reported using an online reporting system which was reviewed weekly by managers. Any incidents involving radiation were reviewed by the Radiation Protection Lead and referred to the Radiation Protection Advisor. Learning from incidents was sent out via email and also discussed at team meetings. We saw learning across all services, for example, a patient was accidentally locked inside a MRI mobile unit. After this incident, lock checks were added to clinic daily checklists. This included both mobile units and host locations.

Staff knew their role and responsibilities regarding duty of candour. Duty of candour states providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving reasonable support, truthful information and a written apology.

Abdominal aortic aneurysm staff advised us that historically, excessive patient scan images were lost or corrupted. In line with national guidance, staff stored images on the patients file on a national database for eight years. Staff improved the image management guide as the image was now attached to scan correspondence and was reviewed by a quality assurance team. Images were checked twice daily to ensure they were saved correctly, and images were only deleted by a named person on a weekly basis.

At a CT clinic in Hereford we saw a patient explained they had a cannula left in following a previous contrast scan and had to go to the local hospital to have it removed. The lead and manager apologised for this incident and explained that it would be internally investigated, and they would be informed of the outcome by letter. The patient explained that they did not want any correspondence sent to their home address as the family were unaware of the procedures that were being performed. The manager agreed and stated that the outcome would be documented in the patient's hospital notes. At the time of publication, the incident was still under investigation.

Are diagnostic imaging services effective?

Not sufficient evidence to rate ●

We do not rate effective for diagnostic imaging.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

We saw several recent reviews by national agencies to ensure compliance with evidence-based practice. For example; Investigation into the management of health screening by the National Audit Office, Review of adult screening programmes by the Department of Health and Social Care, a Screening quality assurance visit by Public Health England and an Environmental permitting regulations inspection by the Environment Agency. For all of the above, Beechwood Hall had met or exceeded standards.

All provider policies and procedures were available online as well as in paper form on each of the units and staff knew how to access them. Managers emailed staff to advise when there was an update to policies and changes to guidance. All emails were sent with a read receipt and staff advised their completion of the read receipt acknowledged they had read and understood the policy and that they would adhere to guidance. Understanding of policies and procedures was included in appraisal. MRI staff knew their roles and responsibilities and where to

find procedures if a magnet required quenching. Quenching is the process whereby there is a sudden increase in temperature in the magnet coils and they cease to be super conducting and become resistive, thus eliminating the magnetic field.

We viewed three site files, all included a protocol table which included company policies, all policies were in date and referenced appropriate legislation. The files also contained; site contact details, emergency and fire procedures and both InHealth and the onsite safeguarding procedures.

Nutrition and hydration

Certain scan lists required patients to be nil by mouth for a period before the scan. Patients advised us this was discussed at booking and was also included in the information pack they received regarding what to expect from the scan. We saw staff check whether patients had consumed food before a scan, when applicable.

Patients receiving a scan of the urinary tract were asked to drink one litre of water 45 minutes before the scan. The booking team contacted these patients the day before the appointment as a reminder and we saw staff checked again when the patient arrived on site.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

We saw staff monitor and record patient pain levels both before and after pain clinics. Staff used a pain scale chart to record patients pain levels.

Patients referred to Beechwood Hall via a physiotherapist were given pain diaries. Staff explained these were to be completed daily and brought to the physiotherapy follow up appointment two weeks after the scan.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

At the time of inspection, the service was working towards accreditation with the Quality Standards in Imaging. We saw managers were in the process of ensuring internal processes related to the standard and were part way through the self-assessment process. The director of clinical quality and the clinical governance lead were both members of the ISAS network and were looking to achieve accreditation towards the end of 2020.

The provider was accredited to Improving Quality in Physiological Services (IQIPS) for adult and paediatric audiology services and were due their next recertification visit towards the end of March 2020.

All referrals from National Abdominal Aortic Aneurysm Screening Programme were followed up with the GP on the same day. The service met with the three referral sites weekly to ensure that referred men with Abdominal aortic aneurysm over 5.5cm were seen by a specialist within two weeks and operated on within eight weeks.

The service regularly undertook discrepancy meetings as per Royal College of Radiologists guidance. Managers notified the governance team of any Category one or two discrepancies. These were urgently investigated and reported into the online incident reporting system.

We saw full root cause analysis carried out by the risk and governance lead. Learning was shared across services as well as with the host trust. We saw evidence of a comprehensive auditing programme with a timetabled schedule of auditing, review and improvement plan. Image quality audits were performed monthly by a central team with local quality audits being completed by the site lead, which included spot checks observing staff during clinical practice. Staff audited 10% of all vascular images on a monthly basis, with the most recent audit scoring 100%. Health care quality audits were scheduled by the head office and completed annually, they included; fire safety, uniforms, patient communication, hand hygiene and health & safety.

Records assessing pregnancy status were saved onto the patient's electronic care record. In PET-CT, a test primarily for the management of cancer pathways, if any possibility of pregnancy is identified, the status is confirmed by laboratory testing carried out by the patient's primary care team to avoid unnecessary delay.

InHealth's Radiation Protection Policy and Local Rules required all female patients aged between 10 and 55 to be asked about potential pregnancy using the safety questionnaire. All incidents relating to the exposure of potential pregnant persons to radiation are reported through the electronic incident reporting and

management system. There had been one incident in the last eight years. Compliance with regulations was reviewed at biannual Radiation Protection Group meetings and we saw learning was identified and shared across all services.

Competent staff

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

All staff we spoke with from each of the six different services stated they had received good inductions. Site orientation formed part of induction as well as a modality specific competency assessment toolkit which covered competency skills relevant to each job role. This was completed within two to four months of an employee starting at the company. MRI staff shadowed a radiographer for four weeks, during which their competencies were assessed. CT staff received work reviews after four, eight and 12 weeks on the job. PET CT staff completed a three-month competency pathway. Their first week was at a static site with two days studying the service and reviewing key policies. Staff then completed observations with a 'buddy' (senior technician). Intravenous therapy training was also completed with observations of cannulation.

Staff wishing to become assessors attended regular training days to ensure the assessment process was consistent. The assessor's observations were recorded on the toolkit and formed the basis for appraisal. Staff we spoke with who were competency assessors stated they were under pressure from managers to ensure staff were deemed competent as soon as possible. Some staff stated they would like more time to go into detail before signing off a competency. Staff advised us they had access to training programmes which were fully funded by InHealth. Some staff we spoke with were completing post graduate qualifications which were university accredited as well as middle management courses. Abdominal aortic aneurysm team is overseen by a clinical skills trainer (CST) who is a senior sonographer/vascular scientist. The team will usually consist of staff working in pairs to ensure effective throughput of patients in the clinic. They are required to undergo regular assessment and to renew their accreditation at intervals as per the National Abdominal Aortic Aneurysm Screening Programme Education and Training Framework. MRI staff had access to simulators and Imaging software to enable the trainees and new starters to gain confidence before moving onto real cases.

The staff appraisal completion rate was 100%. Cannulation competency formed part of the annual appraisal cycle, staff were asked to keep reflective records of a minimum of 10 cannulation episodes per year. Individual learning and development needs were discussed and agreed as part of the annual personal development plan.

There was an in-house leadership development programme, which staff advised us they valued and made them feel there was career progression and "Somewhere to go from here." Assistant staff were given the opportunity to work in different services which they appreciated and said it gave them "more well rounded knowledge". Staff were given the opportunity to present different topics during quarterly meetings. Staff at an ultrasound clinic in Waterloo stated they had recently presented about how to include exercise within the working day. Ultrasound clinical assistants were supported by InHealth to become sonographers if they already had a science-based degree. PET CT managers agreed to train staff in Immediate Life Support instead of Basic Life Support as staff had requested it due to working on mobile units and wanting to feel more confident in an emergency situation. The sonographer at the Portsmouth ultrasound clinic conducted lectures on radiography at universities around the country and had written a book on radiography procedures that at the time of inspection was being translated into Spanish.

Multidisciplinary working

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

Staff said they could access support if they needed help regarding a scan. Managers were available either via telephone or email and responded to queries promptly.

Each service used its own system when staff required a second opinion. In CT, there was a peer review system and rejection analysis that looked for trends where the quality of images was not sufficient. In ultrasound, there was a second opinion team rota. Consultants were on call to support and provide a second opinion when it was required. Senior sonographers reviewed patient referrals

before the patient arrived at the clinic. If they saw something within the referral that was not routine they were able to ensure support was available at the time of appointment.

Staff in ultrasound were working closely with local GP's and physiotherapists to improve referral information. The clinical leads regularly met with primary medical service teams and the reporting templates had been adapted after discussions showed they needed to be clearer.

Seven-day services

Services were available to support timely patient care.

Beechwood Hall organised its clinic locations, frequency and opening hours on the requirements of those they provided a service for.

The nature of the service meant it was flexible and able to be open 'out of hours' and weekends.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Patient consent was sought on the day of the appointment. All staff we spoke with were aware of the requirements relating to mental capacity and consent, specifically for patients that lacked capacity to provide safety critical information. Staff understood that consent could be withdrawn at any point either before or during a scan. We saw staff explain this to patients.

The MRI systems asked radiographers whether they had gained consent for the procedure to go ahead. They could not physically take the scan until they clicked 'yes'. Abdominal aortic aneurysm scanning systems did not allow staff to scan without clicking the consent button on the system. Staff used this time to confirm consent and check whether patients had any questions. In ultrasound, staff completed procedure checklists that included whether consent had been gained by the patient. In CT clinics, consent was gained for the procedure and again when giving contrast. We saw a patient at an ultrasound clinic in London change their mind at the time of the scan and stated they wanted a female sonographer. The scan was rearranged for the next morning with a female sonographer as the scan was an urgent referral.

In the mobile MRI unit in Rochdale we saw staff complete a 'Lack of Capacity MRI safety Screening record'. Booking staff completed an in-depth description of the patient's needs and reason for lack of capacity before the appointment and allocated extra appointment time in order that on-site staff could support the patient. Booking staff ensured the patient was accompanied by an advocate.

Are diagnostic imaging services caring?

Outstanding ☆

We rated this service as **outstanding.**

Compassionate care

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

The patient experience and providing a caring service was embedded within the organisation's mission, values and culture. All staff we spoke with described how important providing a caring, compassionate service was to the various teams.

We saw staff followed the hello my name is campaign. The 'Hello my name is' campaign is focused on reminding staff to introduce themselves to patients properly. It advocates that a confident introduction is the first step to providing compassionate care and is often all it takes to put patients at ease and make them feel relaxed whilst using services. We saw staff introduce themselves to patients by their first name and patients we spoke with who regularly used services advised us they enjoyed the relationship they had with staff.

The Friends and Family Feedback received was consistently positive with 97% of people stating they would recommend the service to their friends and family. A patient we spoke with at a CT clinic in Nottingham advised us they had recommended the service to their friends and all staff we spoke with described the

importance of the patient experience. All staff attended a patient experience training programme to better understand the scanning process from the point of view of patients.

Staff regularly checked whether patients were comfortable throughout the scanning process. Staff advised us "We want to do our best for the patient to get them through as scans are anxiety provoking." Staff in MRI clinics provided eye masks and applied appropriate ear protection to protect patients against the noise of the MRI machine. Patients could either listen to the radio or bring in their own music.

We saw staff treat patients with dignity and respect and where a clinic was located within a host hospital, staff ensured the door to the room was locked during procedures.

During our inspection, we saw examples of staff at all locations going above and beyond, including; At Beaumont CT clinic we saw 31 patient feedback forms. All were overwhelmingly positive about their experience of the clinic and the staff that looked after them. Comments included "Made to feel welcome and at ease, staff very professional and friendly", "Fantastic level of care, very quick and friendly service" and "Perfect attention and care". A patient at a CT clinic in Plymouth, was anxious to know the results of their scan and was very tearful regarding the outcome. Staff gently explained they were not allowed to discuss the findings of the scan and took the time to reassure the patient and kept them on the vehicle until the patient was calm. At an ultrasound clinic in Southampton we saw staff warm the gel before applying it. Staff also advised the patient where they were moving the probe to and whether the patient would feel any pressure. One patient advised they had struggled to get to the clinic. In response to this staff looked online for local public transport services and arranged for reception staff to organise a taxi. We saw staff at a CT clinic in Plymouth support a very anxious bariatric patient. Staff allowed her husband to sit in with her and hold her hands to provide comfort and support. Staff provided reassurance for the patient and took their time with the scan.

Emotional support

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

The MRI clinical lead led a review of the eight C's (consider, compassion, comfort, confidence, communication, control, calming and change) of caring approach to managing anxiety associated with scanning. This was developed in conjunction with the Patient Experience Network to understand patient fears. As a result of this, patients who required an MRI scan who were claustrophobic were placed in the scanner feet first. In Rochdale we saw staff support a claustrophobic patient throughout their scan. Staff kept in continuous contact with the patient via the headphone communication system to talk through the scan as it was happening and checking the patient was alright. A patient we spoke with at an MRI clinic stated, "I was quite anxious and apprehensive, but the team allayed my anxieties." Staff at an ultrasound clinic in Portsmouth supported a patient who fainted. They made the patient sugary tea and gave them a biscuit. Staff stayed with the patient until they had fully recovered and checked their blood pressure. At an ultrasound clinic in Southampton, a male sonographer had been requested by a male patient as they were having an intimate part of their body scanned. This patient was also anxious, and we saw staff talk to the patient about their concerns. Staff were very kind and supported the patient to ensure they were at ease. Staff advised what they were going to do before proceeding, gave the patient privacy and regularly asked the patient if they were ready for the next part of the scan.

We saw staff support patients with a fear of needles. Needle phobia was discussed during the booking process for all clinics involving injections. This gave staff advanced warning. If a patient advised they had a fear of needles, the appointment time was extended, staff ensured an adrenaline pack, bottled water and secondary support was available for the patient's appointment.

Staff in the AAA team received extra training in how to support patients where they had to give bad news. Staff we spoke with advised us the week before inspection they scanned a nervous patient whose results showed a diameter of 5.5cm or over (the point where the threshold for surgical review is reached). They immediately referred the patient to a specialist, discussed next steps and ensured the patient had family support. Staff called the patient a couple of days later to follow up and give the patient the opportunity to absorb the information and ask questions.

Outstanding ☆

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At an ultrasound clinic in Golders Green, we saw patients with dementia and learning disabilities were prioritised and seen at times to suit their needs and were also given longer appointment times. At the same clinic we saw a patient attended with a history of abuse that needed a transvaginal scan. Staff allocated extra time for the scan and senior staff spoke with the patient at length to discuss the process and obtain written consent. We have since been informed the patients GP wrote a complimentary letter to Beechwood Hall for their handling of the situation.

Understanding and involvement of patients and those close to them

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

All patients we spoke with advised us they were kept informed of what the procedure entailed, risks, side effects and next steps. We saw staff talk to patients using plain English and where appropriate, patients, their families and carers were involved in discussions about options for future treatment. A patient at a CT clinic in Beaumont stated they were "Fully informed about what to expect" and patients at a CT clinic in Hereford said they felt listened too and supported if they found it difficult to lie completely still during a scan (this is to prevent a blurred picture). We saw staff at a CT clinic in Birmingham give patients information forms to advise them of symptoms they should be aware of following contrast medium.

Staff investigated ways of understanding the scanning process from the patient's point of view as a way of improving the patient experience. For example, the AAA screening team were in the process of conducting a survey to gain patient views of their experiences using the vascular nurse practitioner service. Patients were offered a vascular nurse practitioner appointment following initial detection of an aneurysm or when a surveillance patient aneurysm changes in size. Therefore, staff felt this was a good method for understanding the patient experience. As a result of the programme to review anxiety, the service had developed a guidance note advising patients what to expect from a scan.

Staff advised us that appointment times were long enough and were planned to allow enough time to discuss the procedure in depth with patients and provided an opportunity for patients, their friends and family to ask questions. We saw staff check whether patients had any questions or concerns during every patient interaction we witnessed.

Are diagnostic imaging services responsive?

Outstanding ☆

We rated this service as **outstanding**.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

The service was planned to support commissioners and local health economies where NHS services did not have the resources or were not meeting national standards in providing a diagnostic screening service.

All services were planned with the host hospital to ensure patients had access to appropriate facilities whether the clinic was held within the hospital or in a mobile unit on the hospital grounds. For example, all patients had access to a waiting area, toilet facilities with disability access and parking. Clinics held in mobile units were located within the host hospitals car park. At an ultrasound clinic in Southampton, patients stated they noticed the impact on parking availability on the days when the unit was on-site.

Clinics were clearly signed at the main entrance of each host hospital site and stated where patients needed to report to. Where clinics were held in a mobile unit, the waiting area in the host hospital was located within easy walking distance to the unit and all walkways had wheelchair access. All mobile unit doors sign posted patients to the main hospital entrance. This was in response to patients seeing the unit in the car park and going directly to the unit instead of first checking in at the host hospital reception.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences.

Diagnostic imaging

The organisation had spent a lot of time reviewing the patient experience and how it could support patients with specific needs and requirements. For example, the newest PET CT scanner had been designed with patient feedback in mind. It had laminate flooring to make it look more like a 'private' unit rather than clinical. It had mosaic designs on the walls which was chosen by patients. Patients were asked what they would like the environment to feel like and the area was designed with their feedback. All PET CT chairs laid flat in case a patient fainted. There was also heated panels in the roof to keep the unit at a constant pleasant temperature for the patients. At the time of inspection staff were reviewing how to improve the patient experience for patients protected under the nine characteristics as detailed in the Equality Act 2010.

The monthly site review included information regarding whether the location supported inclusivity of patients with difficulties communicating, disabilities, or comorbidities. For example, CT scanners were able to support patients with a weight of up to 28 stone. Patients in wheelchairs or those with difficulty mobilizing were able to access MRI mobile units via a lift. We saw lift functionality was included in each mobile units' daily checklist. Staff had access to a language line if a patient did not speak English or English was not their first language. In a mobile MRI unit in Southampton we saw a language identification poster detailing that information leaflets were available in 30 languages. British Sign Language and deaf/blind interpreters were also available.

At the time of inspection, the AAA team were reviewing different ways they could promote screening. The British Medical Journal found that older men are 32% less likely than women of the same age to seek medical support, however, they are the group most likely to suffer an aneurysm. Therefore, the AAA team were part of an aneurysm surveillance programme to promote screening self-referral in men aged 66 and over. Also, the AAA and breast screening team engaged with local learning disability nurses to discuss what support was available to patients with learning disabilities and encourage these patients to attend breast screening scans. This was after a project found that health screening for this patient group focused on their learning disability rather than other possible co-morbidities.

Access and flow

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

The service was designed around being flexible and supporting patients to have a scan at a place, date and time that suited them. The service used a 'Realtime capacity and demand management' system to organise the scheduling of services. This was led by the operational and business development team. Planning of the units was completed between four to six months in advance and reviewed on a weekly/bi-monthly basis.

Patients had the option to book appointments either through telephone, self-booking services or the 'patient portal'. The Patient Referral Centre booked the patient into the next available appointment using a checklist to establish basic patient information, including questions regarding mobility, ability to consent, transport arrangements, height/weight, and any service specific pre-booking questions. Any issues were brought to the attention of the clinical team who advised the Patient Referral Centre if any special arrangements needed to be made. Information about the appointment, including preparation required, was either posted or emailed to the patient. At the time of booking, patients were able to request a specific gender of radiographer or sonographer.

The transport planning team moved the mobile units from site to site, however it was the clinical staff's responsibility to ensure the unit was ready for transportation at the end of each clinic, even if the unit was not to be moved that evening. This was in case requirements changed. Fleet drivers were scheduled a week in advance. Every Thursday the drivers schedule went out for the next week, Sunday to Saturday. The fleet management team had an up to date replacement fleet programme to prevent delay at the point of care.

Mobile diagnostic imaging services were accredited with a national procurement framework. Requests for the mobile units were received either via this route, by direct customer requests or through the mobile planning team. On receipt of a request, the business development team reviewed current and forthcoming contracts to determine availability. If capacity was not available for the timeframe required, this was communicated to the customer with a timeframe for availability.

The National Abdominal Aortic Aneurysm Screening Programme received their annual cohort of clients each

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November before the screening year commences on 1 April. This allowed time to validate the cohort prior to the screening year and enable the team to request information regarding additional requirements needed by eligible patients. During this period the team also calculated the capacity for each clinic throughout the screening year.

The AAA team provided ad hoc clinics at GP practices that specifically requested them, as well as nursing homes as older patients are more likely to suffer an aneurysm but find it harder to travel. The AAA team contacted GP's prior to appointments to check whether patients had a learning disability or cognitive impairment. Staff had access to easy to read notification letters that included pictures.

Key Performance Indicators were set by the host trust and included; referral to appointment, reporting turnaround times and reporting audit. We saw reporting turnaround times within 24 hours of the scan or procedure averaged 90% across services. To help keep 'Did-Not-Attend' (DNA) rates low, administration staff telephoned and/or sent a reminder text to patients on the following day's lists as a reminder of their appointment as well as any preparation that was required.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

The InHealth website clearly showed patients the different ways they could make a complaint and details of the complaint process depending on whether they were an NHS or private patient. The website included contact details for the Parliamentary and Health Service Ombudsman and Independent Sector Complaints Adjudication Service (ICAS). The ombudsman is responsible for considering complaints that the National Health Service in England where the service has not acted properly or fairly or have provided a poor service. ICAS provides independent adjudication on complaints about ISCAS subscribers. ISCAS is a voluntary subscriber scheme for the vast majority of independent healthcare providers. We also saw posters in patient changing areas and clinic rooms that clearly described how patients could complain.

Managers reviewed all complaints reported via the electronic reporting system on a weekly basis. This ensured complaints were investigated promptly and learning shared. All staff we spoke with advised us they were kept up to date with any changes to policy or practice as a result of a complaint as complaints were discussed at all team meetings and changes to practice were emailed to staff with a read receipt response.

Staff were able to describe changes to practice as a result of a complaint. For example, a GP had advised a patient they were to receive two scans. The patient was then confused when they only received one scan at the appointment. Since then the booking team sent details of procedures to the patient prior to the appointment. Letters included a contact telephone number in case the patient had a question or query. Staff at an MRI unit in Southampton advised patient information on the lead up to the appointment had improved since a complaint where the patient did not know how long the procedure was going to take. Staff from the AAA team stated they had received several complaints stating the maps they provided locating clinics were not detailed enough. These were reviewed and improved, since then they had received no further complaints regarding this issue.

Are diagnostic imaging services well-led?

Outstanding ☆

We rated this service as **outstanding**.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had a shared purpose to deliver and motivate staff to succeed. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture. Leaders showed strong collaboration and support across all functions and a common focus on improving quality of care and patient and staff experiences. Leaders were visible and approachable.

Diagnostic imaging

There were clearly defined roles and responsibilities within the leadership team to ensure the safe delivery of the country wide service. All managers knew what was expected of them which was supported by the development of the 'Role of the InHealth People Manager and Leader' document. This detailed the specific duties of each role and their accountability and duties. We saw many examples of managers having access to a leadership development culture including; eight mobile service managers had completed a Level 3 diploma by the Chartered Institute of Management. The level 5 diploma had been completed by all mobile managers. On completion, managers received a talent plan which was reviewed by the providers executive team who arranged a yearly event for managers to share updates and developments. We also saw managers completed a mentorship and coaching programme to aid understanding of employees and managers own behavioural preferences to support better communication.

Line managers were available via email and phone. We saw MRI staff contact their manager who answered immediately. Ultrasound staff advised us that managers attended clinics if they felt they needed extra support. AAA staff advised us that managers checked their well-being regularly, especially when they had a case where they had to give bad news. Managers were available for advice and support for staff working on weekend clinics. PET CT managers advised us they received leadership and management training as well as in-house risk and governance training and training in how to perform a root cause analysis.

Vision and strategy

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. Leaders and staff understood and knew how to apply them and monitor progress.

The strategy and supporting objectives were stretching, challenging and innovative while remaining achievable.

All staff we spoke with knew the company values were; Trust, Passion, Care and Fresh Thinking. A manager stated they felt the values were embedded in people's work and "Staff live and breathe the values". The vision and values were discussed at staff appraisal, team meetings, monthly teleconferences and quarterly face to face meetings. Staff advised us 'Vision and Core Values' formed a large part of the corporate induction and was completed within the first three months of employment.

InHealth's People Strategy detailed the workforce philosophy including what was described as the infinite employment lifecycle of interest, application, joining, developing and performing. It also included the provider plan for retaining staff which included improving the employee experience by a reward strategy, embedding cultural behaviours, providing clear career pathways and reduce ongoing attrition. Managers reviewed the leaving questionnaires of previous employees and noted a lack of engagement as one of the reasons staff left. In response to this, managers focused on improving staff engagement which was reflected in the 2019 staff survey which saw a 5% improvement in questions regarding engagement with staff on the previous year.

The InHealth Leadership Strategy set out the standards expected by the leadership team, which was linked into the providers values. It included information regarding performance management, induction, training, communication and engagement. The strategy also outlined the importance of maintaining the physical and mental health of employees and how managers could support this.

Culture

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

There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff felt respected, supported and valued. The service provided opportunities for career development. The service had an open culture.

Diagnostic imaging

A few staff we spoke with advised us they had left the company but had returned as the support and job opportunities at Beechwood Hall were much better than with other providers.

Different staff worked together on each shift. Staff we spoke with advised us they appreciated this as working with different people ensured they did not pick up "bad habits and stopped complacency".

All staff we spoke with said they "loved the job" and "I love working here". One assistant advised us they had worked in other hospitals in the past and there was a "us and them" attitude from the radiographers and sonographers. They advised that did not occur at Beechwood Hall "It doesn't feel like there is a hierarchy". Staff across locations advised us of the 'Excellence in Everything' award. This was open to all staff and any one could nominate a colleague for example completing a quality improvement project or delivering outstanding care.

Staff had access to a freedom to speak up guardian and a duty of candour policy. Freedom to speak up guardian's, support workers to speak up when they feel that they are unable to do so by other routes.

The majority of staff we spoke with advised us there was some instability regarding recent changes in management. Some staff advised us that gaining authorisation for annual leave had been difficult as the turnover of managers meant no one had oversight and leave requests were cancelled at the last minute. Some staff had requested leave for 2021 but had not received confirmation.

Governance

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

Governance and performance management arrangements were proactively reviewed and reflect best practice. 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.

The service had a clear systematic governance process to continually improve the quality of services provided to patients. These arrangements were clear and operated effectively. Staff understood their roles and accountabilities.

The service undertook numerous quality audits, and information from these assisted in driving improvement and gave staff ownership of things which had gone well, and action plans identified how to address things which needed improvement.

The clinical governance framework included the quarterly risk and governance committee, clinical quality sub-committee, medicines management group, water safety group, radiation protection group, radiology reporting group, MRI safety and quality group, safeguarding board and the weekly meeting for review of incidents and identification of shared learning. An internal quality assurance audit (Health Quality Audit) was undertaken yearly. Where services were delivered to host organisations, monthly quality and governance meetings reviewed quality assurance and contracts.

Fleet breakdown statistics, trailer uptime (time it could be used), up time and down time for scanners and site-specific breakdowns was reviewed via governance systems. Monthly breakdowns and the replacement programme fed in to end of month reviews. The fleet team met with customers every four to six weeks to discuss reserved but not confirmed units, as well as fleet reservations versus availability. The fleet team also had a weekly huddle that was led by a different member of the team and included reviewing a risk report.

Breast and AAA screening teams met three times a month at a programme managers meeting to discuss incidents, local and functional risk register; shared learning presentations; open cases on the online incident reporting system and 'what we do well'.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified

actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Leaders we spoke with had a deep understanding of the issues, risks and challenges faced by the service and a plan of action to mitigate those risks.

Staff knew how to add risks to local risk registers. Risks with a high score were added to the regional risk register. A quarterly report on new and updated risks was sent to the quarterly risk and governance committee. Support with risk assessments was provided by the health and safety advisor and the risk and governance lead who also advised the various registered managers on the correct process to add a risk to the risk register and complete the quarterly risk report. Identified risks were held on each service risk register and reviewed every quarter which fed into the corporate risk register. All risks we identified during the inspection were documented on the risk register.

The quality team completed a monthly audit where they reviewed 10% of scans from randomly selected clinics. These were sent to an approved sonographer or radiologist for review. The team reviewed whether they needed to take further action based on the results.

At the time of inspection, InHealth were accredited against ISO 27001 and 9001 standards which were assessed by an external assessor.

We saw InHealth was subject to a triennial review by NHS England which assessed the working and management of the provider against the standards prescribed within the Responsible Officer Regulations.

The service had a robust business continuity plan in the event of loss of electricity, floods or adverse weather etc. We saw this plan was available to all staff and included clear contingency plans. All staff we spoke with were aware of the plan and knew where to find it.

We reviewed five staff files and noted that all were fully completed, up to date and met the requirements of Schedule 3. Schedule 3 sets out eight categories of information required to be kept by providers about all persons employed in the provision of services. For example, qualifications, full employment history and identification checks.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

All staff had easy access to the intranet where they could access all policies and procedures as well as communicate and receive updates within an electronic communications system. Staff kept electronic patient records secure to prevent unauthorised access to data, however authorised staff demonstrated patient information was easily accessible when required.

Authorised referrers could remotely review information from scans to give timely advice and interpretation of results to determine appropriate patient care.

All staff had undertaken data security and awareness training as part of their mandatory training. Staff we spoke with understood their responsibilities around information governance and risk management.

Engagement

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

Constructive engagement from people who used services and staff was welcomed and seen as a vital way of holding services to account. Leaders and staff actively and openly engaged with patients and staff to plan and manage services.

Staff we spoke with said they were encouraged to complete the yearly InHealth staff survey. The most recent staff survey was carried out in May 2019, with results published in July 2019. The data was reviewed on a team-by-team basis, in line with the organisational structure at the time. Results for Beechwood Hall showed

staff were engaged, with a score of 79%, which was a 7% increase from the previous year and 5% higher than the engagement score for all InHealth staff groups. For all questions where a benchmark was available to compare InHealth to its competitors (17 out of 23 questions), staff answered more positively in all areas, apart from two. Fifteen of the seventeen questions showed responses significantly higher than the benchmark. For example, a question asking whether staff had the information to do their job properly, 86% of staff stated they did, which was 30 points higher than the national benchmark. A question on whether performance was actively managed showed a response rate that was 18 points higher than the national benchmark. Twenty one of the 23 questions were able to be compared with Beechwood Hall staff responses from the previous year. This showed improvement in all areas except four. Action plans showed managerial responses to improve staff satisfaction in these four areas. The four questions with the most positive responses for Beechwood Hall staff were; staff knowing what is expected of them at work, pride at working for InHealth, recommending InHealth as a place to work and wanting to be working at InHealth in two years' time.

Different staff groups set up their own social media groups. Staff and managers communicated a lot by email. They advised us they found conference calls did not work due to the size of teams.

Regional staff meetings occurred twice a year and were led by managers. CT staff stated staff meetings were supposed to occur quarterly but did not due to work load. Staff understood that organising meetings was difficult due to staff shifts and the fact the provider worked country wide meant staff did not live near each other. However, all staff we spoke with felt they could discuss issues with the lead radiographer/manager if necessary.

We saw staff at all locations gave patients feedback forms. Questions included; how likely patients were to recommend the service, a section for comments and optional details of the patient. Responses for 'You Said, We Did' included; Patients were unaware their scan would take place in a mobile unit, the provider stated "For InHealth appointment letters we always advise where the scan will take place. We have worked in partnership with our customers to encourage they add this information to their appointment letters for patients scheduled to be scanned on the mobile units." Patients complained that they could not find the scanner, the provider stated, "Asked hospital to update signage for easy location". Request for additional aid to allow a client to move himself from his wheelchair, the provider stated, "Purchased transfer slide boards".

The Patient Experience Network is a national collaborate patient and user experience expert group to raise awareness of the patient experience. A patient experience document that gave an overview of the patient journey, what mattered to patients and expected staff behaviours and a patient information leaflet, poster and video both received a runner up award at the patient experience network national awards.

Learning, continuous improvement and innovation

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

PET CT staff used F18- Prostate Specific Membrane Antigen (PSMA) instead of the standard F18-Choline scanning for prostate cancer. This was because the tracer (a substance, such as a radioisotope, used in imaging procedures) for F18-Choline is very delicate and unstable during its manufacturing and quality control stage, thus making it less reliable. F18-PSMA is a new tracer that provides better imaging quality and is more stable during production.

The provider used weight-based doses of radiation to reduce staff and patient radiation exposures. This was shown to significantly reduce the radiation exposure to the patient to what was only necessary, without compromising image quality. This in turn reduced the exposure to staff, who were able to administer the tracer and provide assistance following the radioactive injection, resulting in a lower radiation exposure for patients and staff.

A MRI training programme was designed to develop staff new to MRI to an entry level practitioner. It was supported by both external and internal colleagues and was

Diagnostic imaging

bespoke to InHealth with approval by the Society and College of Radiographers. The programme also helped staff prepare for completion of a PgCert in Advanced Practice.

There was internal development of the e-learning modules to support standardised training and awareness of MRI Safety requirements. Incidents and shared learning was conducted through the MR safety and quality group (MRSAQ) for all locations. This provided opportunity for discussion of safety and quality issues. InHealth promoted the annual MRI Safety week each year to promote safety awareness across the organisation.

We saw an article published within the British Journal of Radiology from Beechwood Hall staff. The article stated MRI incident reporting numbers nationally are low, suggesting good practices are upheld, staff culture around reporting needed to be continuously developed to ensure staff felt secure in reporting incidents. It also stated that as MRI incidents did not need official reporting "Defining an industry wide classification scheme for incident reports in Diagnostic Imaging would allow for better inter institutional comparison and development of national performance benchmarks."

Staff presented posters and oral presentations at the national radiological conference in order to share good practice with other providers. Presentations included; 'Case files' which detailed how a routine scan detected large leaking infrarenal abdominal aortic aneurysm, the patient was immediately referred and feedback from the hospital showed they made a full recovery. 'What matters in MRI', compared the different aspects of the scanning process and which mattered the most to patients to what staff thought mattered to patients.

As part of an InHealth wide initiative, the abdominal aortic aneurysm team contributed to a project aimed identifying opportunities to improve patient communications which are tailored to the target different cultural communities.

Outstanding practice and areas for improvement

Outstanding practice

- The nature of the service being provided out of small clinics and mobile units meant the service was very flexible. The focus was on providing patients with a service that meant they had choice as to dates, times and locations of scans.
- The culture of the organisation was focused on the patient experience and how to provide outstanding care. We saw numerous examples of staff going 'above and beyond' which we have detailed within the report.
- Staff working in Magnetic Resonance Imaging had completed a large project in conjunction with a patient network group to use the eight C's of caring; consider, compassion, comfort, confidence, communication, control, calming and change, to better understand patient anxiety in relation to scans and make changes to practice as a result of these findings.
- Abdominal Aortic Aneurysm screening staff provided services at residential and nursing homes to support patients with difficulties getting to a clinic. This was to support older men, the group of patients most likely to suffer an aneurysm.
- Staff worked with learning disability nurses to promote the importance of breast screening for patients with learning disabilities. This was after a project found that health screening for patients focused on their learning disability rather than other possible co-morbidities.
- The strong culture of improvement and innovation from the managerial team allowed staff to develop their skills and the service to improve.

Areas for improvement

Action the provider SHOULD take to improve

The provider should ensure mobile MRI units have a barrier across the scanning room door.