Barnet MRI Centre

Quality Report

Barnet MRI Centre,
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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?	**Not sufficient evidence to rate**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Overall summary

Barnet MRI Centre is operated by InHealth Limited. The service is situated in a unit shared between the provider and the NHS host trust. The unit sees both NHS and private patients on an outpatient basis; as well as providing a service for inpatients from the host trust. Both adults and children under 18 years old are seen at the unit.

The unit contains one MRI scanner that belongs to a third party. The unit is separately staffed by InHealth. The opening hours are Monday to Friday, 7am until 9pm, and Saturday and Sunday, 8am until 8pm.

The service is part of the host trust's 'one stop shop' for prostate and breast cancer clinics.

Summary of findings

We inspected this location under our diagnostic and imaging inspection methodology. We carried out our visit as an unannounced inspection lasting one day, on 24 January 2019, with two CQC inspectors and a specialist advisor.

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

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

Services we rate

This was the first time we rated this service. We rated it as good overall.

We rated this service as good because:

- Staff completed and updated risk assessments for each patient. MRI safety questionnaires were completed by all persons entering the MRI scanning room to ensure their safety. This included patients and staff. There was a specific protocol in place for any pregnant patients requiring a scan. Staff escalated any concerns to an appropriate clinician immediately before the patient left the unit.
- Staff treated patients with kindness and understanding. They reassured patients and, where necessary, sat with them throughout their scan to support and reassure them.
- There was effective multidisciplinary working between staff working across the provider and the host trust. The superintendent radiographer attended the daily bed meeting to establish the patients requiring MRI scanning for that day. Certain appointment times were kept free to accommodate the host trust inpatient scan requests.
- The service planned and provided services in a way that met the needs of local people and people could access the service when they needed it. Patients could be seen seven days a week, from early in the morning until late at night.

However:

- There was no service level agreement (SLA) between the host trust and the provider, or with any third party for the provision of services at the location. This included cleaning of the shared unit, attending crash calls and waste management.
- There was no security in place to prevent unauthorised entry to the unit. This was a risk to patients and staff alike. A business case had been put forward to address this issue; however, at the time of our inspection, there was no security in place.
- Patients did not always have their privacy and dignity maintained. The scanning viewing room was also the team office and therefore did not afford privacy to the patient inside the scanner.

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

Dr Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South East England)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	Diagnostic and imaging services at this location were shared with the host trust. It consisted of one MRI scanner and shared facilities. We rated this service as good overall.

Summary of findings

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Good

Barnet MRI Centre

Services we looked at
Diagnostic imaging

Summary of this inspection

Background to Barnet MRI Centre

The service opened in 1999. It is a private unit based within in Barnet General Hospital, North London. The unit primarily serves the communities of the North London area. It also accepts patient referrals from outside of this area.

The unit did not have a registered manager, although an application was in progress at the time of the inspection.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,one other CQC inspector, and a specialist advisor with expertise in diagnostics and imaging. The inspection team was overseen by Terri Salt, Head of Hospital Inspection from London North.

Information about Barnet MRI Centre

The service is a unit based inside an NHS trust; it is registered to provide the following regulated activities:

- Diagnostic and screening procedures

The unit was shared with the NHS trust for diagnostics and imaging purposes. Within the unit, there were three entrances; these were through the main front entrance to the unit, or via the host trust accident and emergency department or radiology department.

The provider had one room where the MRI scanner was housed, and shared the waiting areas, changing rooms, cannulation room and second waiting area with the trust. They also shared the reporting office with the host trust.

During the inspection, we visited all areas within the unit. We spoke with five members of staff including; the operations manager, senior radiographers, radiographers and health care assistants. We also reviewed patient notes as part of our inspection. During our inspection, we did not have the opportunity to speak with any patients.

There were no special reviews or investigations of the unit ongoing by the CQC at any time during the 12 months prior to this inspection. The service has been inspected twice, and the most recent inspection took place in 2013. This found that the service was meeting all standards of quality and safety it was inspected against.

Within the unit, there was a senior radiographer, radiographers and health care assistants. All reading of reports was sourced out to a third party and to a radiologist working under practising privileges from the host trust. At the time of our inspection, the unit did not have a registered manager; the application process for a new registered manager was underway.

Track record on safety

- There had been no never events
- There had been 48 incidents between November 2017 and November 2018 and three complaints.
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA)
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-Coli

Services accredited by a national body:

- Investors in People (Gold award)
- ISO 9001: 2015
- ISO 27001: 2013
- Improving Quality in Physiological Services (IQPS)

Summary of this inspection

Services provided at the hospital under service level agreement:

- There was no service level agreement between InHealth and the host trust.

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:

- Staff completed and updated risk assessments for each patient. MRI safety questionnaires were completed by all persons entering the MRI scanning room to ensure their safety. This included patients and staff. There was a specific protocol in place for any pregnant patients requiring a scan. Staff escalated any concerns to an appropriate clinician immediately before the patient left the unit.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service 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.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.
- The service followed best practice when giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

However:

- Although the service controlled infection risk well, and all areas we visited were visibly clean, the service lacked effective systems and processes to ensure standards of cleanliness and hygiene were maintained. There was no service level agreement between the provider and the host trust to provide cleaning services and staff did not routinely review cleaning schedules or audits.
- There was no security in place to prevent unauthorised entry to the unit. This was a risk to patients and staff alike. A business case had been put forward to address this issue. However, at the time of our inspection, there was no security in place.

Are services effective?

Not sufficient evidence to rate

We currently do not rate effective for this type of service.

Summary of this inspection

However, we found:

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff were aware of the need for informed consent and we saw that each patient signed a consent form prior to their procedure.
- There was effective multidisciplinary working between the provider and the host trust. The superintendent radiographer attended the daily bed meeting to establish the patients requiring MRI scanning for that day. Certain appointment times were kept free to accommodate the host trust inpatient scan requests.
- The provider scanned patients seven days per week, from early in the morning until late at night to provide access to a variety of patients.

Are services caring?

Good

We rated caring as good because:

- Staff interactions were kind, caring and professional.
- Patient feedback was actively sought and used to improve the service.
- Staff provided emotional support to patients to minimise their distress.
- Patient feedback was positive about the service. The service could provide a chaperone if required.

However:

- Patients did not always have their privacy and dignity maintained. The scanning viewing room was also the team office and therefore did not afford privacy to the patient inside the scanner.

Are services responsive?

Good

We rated responsive as good because:

- The service planned and provided services in a way that met the needs of local people.
- Services were planned to take account of the needs of different people.
- Patients were offered a choice of appointments and we saw that the service was planned in a way to allow for timely access to diagnostic imaging.

However:

Summary of this inspection

- Bariatric patients were not able to be seen at the unit, and had to be referred to an alternative unit.
- Signposting to the unit was minimal and difficult to see. The unit was hidden behind the ambulance parking bay and behind repair works being carried out. Access to the unit was difficult for those with mobility issues as the ramp needed to be replaced.

Are services well-led?

Good

We rated well-led as good because:

- Staff told us they felt supported, respected and valued by the organisation. Staff told us the local leaders were visible and approachable.
- The leadership team for the provider were clear on vision and strategy for the unit.
- There was an effective governance framework to support the delivery of good quality care.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- Patients' views and experiences were gathered and acted on to shape and improve the services and culture.

However:

- There was no service level agreement (SLA) between the host trust and the provider (or any third party) for the provision of services at the location. This included cleaning of the shared unit, attending crash calls and waste management.

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	Good	Good	Good	Good
Overall	Good	Not rated	Good	Good	Good	Good

Good

Diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

This was the first time we have rated this service. We rated it as **good**

Mandatory training

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

All substantive staff that had completed their probation had 100% compliance with their mandatory training. There were three new members of staff that had joined the unit and were in the process of completing their training. The mandatory training consisted of: fire safety and evacuation, health and safety in healthcare, equality and diversity, infection control, moving and handling, safeguarding adults, safeguarding children (level 2), data security awareness, customer care, basic life support (BLS), MRI safety level 1, MRI safety level 2a, MRI safety level 2b and patient transfer training (PTT).

Mandatory training was delivered both online and face-to-face. The provider had an electronic system that flagged when a colleagues mandatory training was about to expire. Training was provided monthly on an electronic learning (e-learning) basis. We were able to see that training for a member of staff was due to expire within the next two months. This employee was already booked on their basic life support (BLS) training for the beginning of March 2019; this included their patient transfer training.

Safeguarding

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

All staff were trained to safeguarding children level 2; as the unit was able to see children of all ages. They also had access to members of staff within the trust who were level 3 trained, as well as those with level 4 training within their own organisation. There was no agreement with the host trust for their responsibility with regards to safeguarding for InHealth patients, or those attending the unit via trust referral. Between January 2018 and January 2019, 733 children had been scanned in the MRI unit.

Within InHealth, there were two appointed safeguarding leads, one of whom was the director of clinical quality, and the operational manager who both held a level 4 safeguarding training. The superintendent radiographer was the InHealth local safeguarding support officer on site. Safeguarding information and details of the lead were displayed clearly in the shared scanning operational office. This information poster contained the bleep number for the child protection hotline, named doctor, named midwife, hospital social work team and a contact for social services.

The provider had a safeguarding children policy in place. This policy was issued in August 2018; therefore, it was in date.

Approximately 18 months ago, one adult safeguarding referral had been made by the provider. There had been no other referrals by the unit to date.

All patients were given a three-point check when undergoing an MRI scan. Patients were asked their name and date of birth, and the scan they were attending. Patients uncomfortable with being alone or that felt vulnerable were able to request a chaperone to accompany them through their appointment.

Cleanliness, infection control and hygiene

Although the service controlled infection risk well, and all areas we visited were visibly clean, the service lacked effective systems and processes to ensure standards of cleanliness and hygiene were maintained. There was no service level agreement between the provider and the host trust to provide cleaning services and staff did not routinely review cleaning schedules or audits.

The service shared the unit with the host trust. The host trust took the responsibility for cleaning schedules within the department; however, the provider was not privy to the outcomes of audits. They were not able to verify the cleaning schedule had been completed as required; therefore they could not be assured this had been carried out as required.

We were provided with a completed cleaning checklist for the MRI scanning room that the provider was responsible for cleaning. This was up to date and had been completed daily. There was no service level agreement between the provider and the host trust to provide a cleaning service. The superintendent radiographer and the administrative officer were both infection prevention and control (IPC) support officers locally at the unit for the provider. The operations manager was the local lead for IPC within the unit. Cleaning audits from a third party were provided after our inspection to evidence IPC within the unit. This was a shared unit and the third party acted on behalf of the host trust to provide a cleaning service. The audits supplied were for the months September 2018 to February 2019 inclusive. The highest compliance score was 94.51% from November 2018 and the lowest score was 87.04% from February 2019. No action plans were provided with the audits for areas of improvement.

The host trust took responsibility for cleaning all areas and equipment within the unit, except for the MRI scanner itself. The provider agreed this with the host trust to ensure the safety of those near the scanning unit. We were provided with evidence that InHealth staff were trained and the MRI scanner and scanning room were properly cleaned daily, although no audit was available. A safety checklist and thorough training had to be provided prior to cleaning staff attending the area. The MRI scanning equipment that came in to contact with the patient was wiped with an appropriate disinfectant wipe.

Within the second shared waiting area, there was a sink with soap and paper hand towels available. The sink contained an elbow tap as per HBN 009 regulations. There was also a single hand gel dispenser attached to the wall between the MRI and CT scanner rooms. Other hand gel was available elsewhere for staff use inside the cannulation room and MRI scanning room. Within the cannulation room, a further sink was in place, again with soap, elbow tap and paper towels available. There were also antibacterial wipes available for use within the cannulation room. We observed staff bare below the elbows and using hand gels where appropriate. We also observed staff washing their hands as set out in the 'five moments of handwashing' protocol. Between January 2018 and February 2019, five hand hygiene audits took place. These were during October, November and December 2018, and January and February 2019. Two of the audits were based on observing three members of staff, two audits observing four members of staff and one observing five members of staff. October 2018 scored 95% compliance; this was due to a member of staff not washing their hands before/after wearing examination gloves. November and December 2018, and January and February 2019 scored 100% compliance.

All the chairs observed within the unit were of a wipe clean material. Appropriate bins were within the unit, and colour coded for the type of waste they were suitable for. A variety of disinfecting wipes were available within the unit for different uses. For example, there were spill wipes, sporicidal wipes, alcohol wipes and universal wipes.

Headphones were available within the scanner for patients to listen to music. Disposable earphone covers were used for each patient for infection prevention and control (IPC) purposes.

Environment and equipment

The service had suitable premises and equipment.

The environment was maintained by the host trust. The service shared facilities with other services, as the MRI

scanning room was within the same area as the CT scanning room. There was a main waiting area with an external door that was also shared with the host trust. This led onto the ambulance waiting bay. There was very little signage to indicate the location of the scanning room, which was not easy to find. Once at the door, there was a buzzer entry system which led directly to the reception and waiting area. This reception desk was unmanned. Staff occasionally went out into the waiting area to call patients through for their scan and to check on other patients.

The area was bright and visibly clean; however, some repair works were taking place at the time of our inspection, therefore part of the waiting area was closed off for safety. This was also evident outside of the unit and left very little pavement space to walk to the front door.

Once called through for a scan, patients were taken to another shared area of the unit. This contained two shared changing rooms, a shared cannulation room, shared office and further shared waiting area. There were a few chairs outside of the MRI scanning room, where patients were indicated to take a seat whilst they waited once changed. This area also contained a sink and an alcohol gel dispenser. All areas visited were visibly clean and well lit.

Two lockers were available for the use of MRI patients only. This was attached to the wall to prevent it falling. There was no designated sluice area within the unit. The provider had to use the sluice area based within radiology department at the host trust.

All equipment, except the MRI scanner, was maintained by the host trust. This was also the case for consumables and linen. Oxygen cylinders were changed by the host trust porters. Cannulas, saline and other consumables were sealed and in date, ready for use.

Sharps bins were reusable. They were collected and the contents disposed of by the host trust. Once the bins had been emptied and sterilised, they were returned to the department. The sharps bin was labelled, signed and in date. It was temporarily sealed when not in use as a design feature. This was attached to the cannulation trolley. The cannulation chair was purpose built and had arm rest and a reclining function.

The MRI scanner was owned and serviced by a third party. It was due for replacement early in 2019; this was being arranged at the time of our inspection. The replacement of the machine was due to its age and amount of usage. If the MRI scanner was unable to be used due to fault or other issue, a mobile scanning unit could be provided by the contractors; it was possible to have the mobile unit in place within one day of the request.

Equipment used within the MRI scanning room was checked daily. We were able to see the evidence of daily checks taking place. This included checking helium levels within the MRI scanning room, as well as oxygen levels, the suction unit, the pocket mask, the bag valve mask, the emergency call bell and the first aid box. We found disposable examination gloves of varying sizes, hand gel, eye masks for claustrophobic patients and sharps bins contained within the MRI scanning room. Also present was an 'MRI safe' fire extinguisher, accessory foam pads for positioning within the scanner (covered in a wipe clean material), and medications used for contrast scanning.

Outside of the MRI scanning room, there was a large danger sign on the floor warning patients, relatives and staff of the dangers of entering the scanning room. Within the MRI scanning room, there was also a tensa barrier that was slightly set back from the inside of the door, in case someone entered the room. This was a further safety feature to prevent unauthorised access to the MRI scanner.

There was a resuscitation trolley that belonged to the trust based at the nurses' station within the radiology department. This area was on the other side of the doors to the MRI department, therefore easily accessible. This trolley was the responsibility of the host trust; however the InHealth staff checked the checklist daily on the resuscitation trolley to ensure the checks had been completed.

There was a plug socket without a cover situated in the shared waiting area. This plug socket was just above the row of seats and easily accessible to all patients including children. There was a control of substances hazardous to health (COSHH) inventory, which was seen and checked.

Assessing and responding to patient risk

Good

Diagnostic imaging

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

Within the second shared waiting area, there were doors that allowed access to the unit via the emergency department and via the radiology department of the host trust. These doors were freely opening and no security measures were in place to prevent unwanted access at any time to the unit or the scanning room. The provider had this risk placed on their risk register during 2018. However, it had been noted on the past two CQC inspections that this was a risk. A business case and plan had been put forward to the host trust, asking them to add security to the department. Part of this had been authorised and within two weeks of our inspection, it was planned that a secure fire door would replace the door to the emergency department; this would only allow patients to exit the department, rather than enter. Further discussions with the host trust were ongoing for the remaining doors that opened out onto the radiology department. The cannulation room had a secure keypad in place and this was utilised.

All patients had to complete a patient safety questionnaire before they were allowed into the second waiting area outside the scanner. This included questions on pregnancy to ensure the patient was 'MRI safe'. The questionnaire also recorded patient name, ID number, and date of birth, weight and height.

Patients scanned outside of the referring clinicians working hours were sent to the emergency department if anything suspicious was revealed on the MRI scan. This was a safeguard for the patient implemented by the InHealth team. During working hours, the radiologist would contact the referring clinician and send the patient either to the clinician or to the emergency department for further investigation.

All patients requiring a contrast MRI had their blood chemistry checked prior to any administration of contrast dyes. The blood test results had to be within the last three months for them to be valid. The clinical assistant checked to make sure the blood tests had been carried out within the appropriate time frame at the time of the appointment booking. When a patient required cannulation and contrast dye administration, the batch number of the contrast and the date were recorded on the electronic patient record, as well as the site of cannulation. For cannulation, the number of attempts and the gauge size of the cannula was also recorded. All kidney test results were recorded and the sample and record were signed and dated by both the patient and the radiographer.

Patients having a scan with a contrast dye were checked for any risk of allergy prior to administration. Once the scan had completed, the patient was asked to wait for a period of 10 minutes post scan, in case of any delayed reaction to the contrast dye.

Once the radiologist was confident the patient was safe, they removed the patient's cannula and allowed them to leave the department.

Pregnant patients were vetted by a radiologist prior to any scan being agreed. A specific protocol was in place for any scans that were able to go ahead under these circumstances. The radiologist had to vet the patient and their circumstances and risks prior to agreeing any scans.

Weight charts were on the wall within the MRI scanning room. This gave the weight limits for the 'MRI safe' scanner, wheelchair and trolley bed.

Cardiac arrests are possible in any setting; the unit had specific protocol for patients within the MRI scanner if they went into cardiac arrest. They removed the patient immediately and took them through to the nurses' station within the radiology department. Whilst moving the patient, they commenced cardio pulmonary resuscitation (CPR). Whilst moving the patient, a designated colleague from the unit would call the trust crash team to attend the location to take over the care of the patient. The same protocol was in place for patients using the mobile scanner; however, there was no service level agreement (SLA) to confirm joint responsibility with the host trust for providing this service.

If the scanner was out of service, or had a fault, the provider was able to request a mobile unit to be put in place outside of the building, whilst the static machine was repaired. Until the unit was operational and potentially a mobile scanner delivered, patients were rebooked for their appointments. If the scan was urgent, they were able to be referred elsewhere or to another trust. At times of high demand, the mobile unit could also be requested. At the time of our inspection, there was no mobile scanner on site.

Good

Diagnostic imaging

Staffing

The service had enough clinical assistant staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

There were no nursing staff employed by the provider at the unit. However, there were four clinical assistants employed, as well as an administrative manager. Staff worked shifts, either between the hours of 7am until 8.30 pm, or 9.30am until 9pm. There was always a minimum of two clinical assistants working each shift. Clinical assistants completed mandatory training, as well as competency based assessments as part of their induction. They completed MRI safety 1, 2a and 2b as part of their mandatory training.

Play therapists were available to assist children having an MRI scan. They were host trust staff, and not part of the unit. There was no SLA for this provision. Level 4 safeguarding trained colleagues were available via the host trust and through the provider via telephone. A children's nurse was available via the host trust if required.

Medical staffing

The service had enough radiology staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

There were no consultants or doctors employed by the provider at the unit. However, there was one superintendent radiographer, four senior radiographers and a trainee radiographer. Staff worked shifts, either 7am until 8.30pm, or 9.30am until 9pm.

The provision of bank staff was through the pool of staff that were InHealth employees. No other additional staff were used within the unit. Bank staff who had not worked at the unit for an extended period of time were required to refresh their knowledge of policies and procedures, and ensure mandatory training was up to date, prior to working a shift. Staffing for the unit was set by a staffing calculator. This was a tool developed by the provider, based on experience, opening hours, training requirements and activity levels. The operations manager was responsible for the staffing levels at the unit, and had the authority to flex staffing levels as required, and as demand dictated. If agency staff were required, they were selected from a preferred supplier. Their CV and references had to be presented, and all mandatory training had to be completed. Policies and procedures had to be read and understood. The locum agency took responsibility for checking the locum's work experience record, and all pre- employment checks via a pre-employment checklist agreed with the provider. All bank and agency staff were required to complete an MRI safety questionnaire and confidentiality statement on their arrival to work on the first day.

Records

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

InHealth staff were able to access patient referrals and records via the trust electronic patient record (EPR) system. Once MRI scans were complete, they were sent via the EPR system to the consultant or radiologist for interpretation. InHealth staff had access to the trust system, so that scans were able to be placed directly within patient records. The radiologist and consultants interpreting the scans were employed directly by the trust.

The provider had a service level agreement with a third party to carry out the task of reporting scans. The third party carried out a radiologist report audit for private patients seen at the unit; this was called a clinical audit. We were provided with results for August and September 2018. For both audits, a sample size of three reports was used, and they were both classed as 'category five'. This meant there were no discrepancies identified and no image quality issues found. There were no other radiologist audits provided. The provider did not participate in any audits collected by the NHS. Instead, they were given snapshots of feedback by the host trust for quality and the number of patients seen. We did not have access to this information as part of this inspection as it belonged to the host NHS trust.

For private patients attending InHealth for an MRI scan, the same trust radiologists reporting NHS scans reported for private patients based on a practising privilege basis

with the provider. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital.

The reporting of scans was always through a third party. Audits were carried out by a third party to ensure the reporting of scans was consistent and in line with policy. The provider received regular reports to show the outcomes of the audits. The reports that we saw evidenced compliance and consistency with agreed standards.

Medicines

The service followed best practice when giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

Medicines were managed centrally with the provider under the medicines management group. This group met on a quarterly basis. Medicines advice was available through the provider via the organisational pharmacist support. This was an external advisor. The superintendent radiographer was the lead for medicines safety within the unit. The unit had access to the chief and deputy chief pharmacist at the host trust, although there was no service level agreement (SLA) in place. The service did not use any controlled drugs at this location.

Patient Group Directives (PGDs) were available on the InHealth intranet; these were for the use and administration of gadeteric acid, gadoxelate disodium, hycosine-N butylbromide and oxygen gas. PGDs provide a legal framework that allows registered health professionals to supply and administer specific medicines to a predefined group of patients without them seeing a prescriber. All of these were in date with a clear review date stated. These were available on the provider's intranet, as well as hard copies within the unit. All drugs kept within the unit for MRI scanning were stored correctly and out of reach of patients.

Radiographers had been trained to cannulate and administer contrast dyes to patients for MRI scanning purposes as required. The certificates of completion and competence were held centrally by the provider, and no copies were kept locally.

There was an anaphylaxis box that was kept in the MRI scanning room. All medications and consumables contained within the kit were in date and checked by the unit.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

A never event is a serious incident that is wholly preventable as a guidance, or safety recommendations providing strong systemic barriers, are available at a national level, and should have been implemented by all providers. The event has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined. The service did not have any never events or serious incidents in the reporting period October 2017 to October 2018. They did not make us aware of any incidents of this nature up until the time of our inspection in January 2019.

The service reported 48 incidents between November 2017 and November 2018. The regular theme of incidents was due to incorrect referrals of patients for scans with pace makers which could not be carried out. Patients with pace makers are not able to be scanned due to safety issues.

The service had reported an unexpected death; this was a patient under the care of the host trust. The provider assisted in the investigation and cooperated with the host trust. There was no further action for the provider as a learning outcome from this death.

The duty of candour was understood by staff; however, the provider had not been required to utilise this for the incidents that had occurred within the last 12 months. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients or other relevant persons of certain notifiable safety incidents and provide reasonable support to that person. The duty of candour procedure was found within the providers adverse events (incidents) reporting and management policy.

Good

Diagnostic imaging

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We do not rate the effective domain for this type of service.

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.

The provider benchmarked themselves by using key performance indicators (KPIs). These included the number of scans achieved each month, variance and feedback. These were discussed at local team meetings and at the CLIC (complaints, litigation, incidents and compliments) meetings weekly.

Evidence was presented to show the provider followed guidance from Medicines and Healthcare Products Regulatory Agency (MHRA). This was in the form of a document produced in conjunction with the health and safety executive (HSE), The Society and College of Radiographers (SCoR), and British Association of Magnetic Resonance Radiographers (BAMRR), amongst other organisations. The document showed cautions, levels of training, risks and contraindications. Although the provider utilised this document, there were no audits produced for benchmarking against other organisations or for improvements.

The provider benchmarked itself using the system of key performance indicators (KPIs). These KPIs reported the number of scanning days, number of patients scanned, documented the number of patients that did not attend their appointment, complaints and when the mobile scanner was required for use.

Nutrition and hydration

Staff gave patients access to water to meet their needs.

The host trust provided a water fountain within the shared waiting area. It was well stocked with plastic disposable cups. There were no vending machines or other facilities within the unit. Within the host trust, there was a restaurant and coffee shop available for patients to visit.

Pain relief

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

The unit did not hold any pain relief medications for patients. If an inpatient required pain relief, they were able to contact the patient's consultant or doctor to prescribe medication.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them.

The unit was working towards Imaging Services Accreditation Scheme (ISAS) accreditation. This is a national scheme for standards across physiological services.

Regular discrepancy meetings took place as per The Royal College of Radiologists (RCR) guidelines. These meetings were held by a third party and externally to the provider, and therefore no minutes of meetings were available. The third party shared their findings with the provider three times per year at quality meetings. The provider met with the third party quarterly to assure themselves of the accuracy and quality of reports. Discrepancies with reports for private patients were referred to the reporter on an individual basis for learning.

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.

Between October 2017 and October 2018, the provider reported all staff had completed their appraisals. All clinical staff had their professional registration verified during the same time period. All staff had been revalidated within the same 12-month period. The provider kept a local checklist of professional registration checks, and when these were due to expire. These were all in date.

All staff had completed their induction, except the three new colleagues. Induction checklists were in place and had been started. The target for completion of the inductions for the new employees was by the end of April 2019. At the end of the induction period, a personal development plan was put in place for the following nine to 10 months. The induction programme included a competency document for staff to complete through their first months with the provider. This included all aspects of working within the unit, from patient care, through to clinical details for positioning, and conducting MRI scans on patients. We saw the 36-page document and how staff were assessed for their competence.

The appraisal year ran from October to October. For the year 2018/2019, all staff appraisals had been completed, and four members of staff had their objectives set.

All radiologists working under practising privileges were substantive staff working within the host trust. The same radiologists reported for NHS and private patients.

Staff that had undergone cannulation training had their certificates held at the InHealth head office. These were not available for us to see at the time of our inspection. Competency documents were provided for radiographers to complete at the time of their induction. An authorised work-based assessor (superintendent radiographer) assessed each colleague based against a framework to ensure competence. We were provided with evidence to show all radiographers had completed the competence document to the required standard.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Radiologists, health care assistants and other healthcare professionals supported each other to provide good care.

The provider received referrals from the host trust, other NHS trusts local to the facility, local GPs, private hospitals and private patients. The majority of the patients attending the unit were from the NHS. Private patients were referred by a clinician and the referral forms were sent to the provider to fill the request.

The radiographers conducted the scans as required and sent the results to the referring consultant for reporting and interpretation within the trust. Each day, the lead superintendent from the unit attended the trust morning bed meeting. This ensured a smooth running clinic and appropriate timings for inpatients; they were able to triage urgent inpatients requiring scanning on the same day to provide this service to the host trust. Time slots were allocated to the trust for this purpose each day.

The provider assisted the host trust as it was an integral part of the prostate and breast clinics. Patients attending these clinics requiring imaging were sent to the MRI unit for their scans. Scans were uploaded onto the EPR system and sent to the specified radiologist for reporting, and then the results were sent to the referring consultant ready for when they saw the patient next. This was part of the host trust 'one stop shop' for certain conditions, such as prostate and breast cancer.

There was a good working relationship between the provider and the host trust. They engaged regularly and attended meetings together. Radiologists were able to feedback any concerns to the trust at discrepancy meetings. The provider worked closely with the host trust for paediatric patients. Children's nurses and play therapists were available to assist when children were seen at the unit as required. They were not permanently based within the department.

Patients attending the unit outside of normal working hours were able to be referred to the host trust emergency department if suspicious or urgent findings were obtained on their scan; this was to ensure the safety of patients and minimise risk.

Seven-day services

The unit was open Monday to Friday, 7am until 9pm, and weekends 8am until 8pm. Outside of these hours, patients at the host trust requiring an urgent MRI scan were sent to an alternative local trust that had availability to provide this service.

Consent and Mental Capacity Act

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.

Good

Diagnostic imaging

Every patient seen within the unit for an MRI scan had to complete a patient safety questionnaire. This was to ensure no harm could come to the patient as a result of the high magnetic field used by the scanner. As part of the questionnaire, a signature at the bottom of the form was required to consent to the procedure taking place, after having received all relevant information to make an informed decision. For patients under 16 years old, a parent or guardian's signature was required. This was countersigned by the validating radiographer.

Where there was concern that a patient lacked capacity, specific consent forms had to be completed. The consent form had to be signed by two separate doctors in the best interests of the patient, as per the mental capacity policy.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Compassionate care

Staff cared for patients with compassion. Written feedback from patients confirmed that staff treated them well and with kindness.

Patients were asked to complete a safety questionnaire prior to going ahead with their MRI scan. The procedure was then explained to the patient and communication was maintained throughout the scan; this took place via a speaker from the safety of the office viewing area through to the MRI room. Patients were able to communicate verbally with staff through the speaker.

Music was available for patients whilst they were within the scanner to help them relax and feel less anxious. For claustrophobic patients, they could be placed in the machine feet first as a compromise, or offered eye masks to wear whilst within the machine. Patients whom were very nervous were allowed a relative or friend to go into the scanning room with them during their scan, provided they were classed as 'MRI safe'. The relative or friend would also be required to complete an MRI safety questionnaire prior to being allowed to accompany the patient to the scan. This applied to all patients, including parents of children seen at the unit. Radiographers had undergone training in recognising the claustrophobic patient and how to assist them through the scanning process.

At the end of their appointment, patients were asked to complete a form regarding their care and experience within the unit. We saw comment cards from 10 patients. Eight of these patients said they were 'extremely likely' to recommend the service, whilst two stated they would be 'likely' to recommend the service. The friends and family comment cards included comments stating: 'was comfortable the whole time, very quiet and easy', 'very helpful and friendly- clear instructions', and 'The service and treatment from all who attended to me was first class'.

We observed a claustrophobic patient going in for their MRI scan. They were very worried and concerned. They were offered an eye mask and given reassurance by the radiographer. The radiographer went in to the scanning room and held the patients hand with their consent during their scan. The patient was very thankful and grateful for the care and time they received from the staff within the unit.

Prior to appointments, patients were sent an information leaflet with their appointment time and date. This contained contact details for patients, in the event they had any questions. Staff were always on hand and happy to answer any questions at the appointment as well.

Emotional support

Staff provided emotional support to patients to minimise their distress.

The feedback received from patients was very positive. Patients were very complimentary regarding the care that they had received. Staff had been able to answer patients' questions and give clear instructions as to the tests and scans patients were about to undergo.

Leaflets were sent out to patients describing MRI scanning with their appointment letter. Within the main shared waiting area, there were leaflets and posters providing information to patients due to undergo an MRI scan.

Understanding and involvement of patients and those close to them

Good

Diagnostic imaging

Staff involved patients and those close to them in decisions about their care and treatment.

Patients' relatives or carers could wait with the patient in the main waiting area. Once they were taken through for their scan into the second shared waiting area, they were seated by themselves or with a fellow patient. The reception area was unmanned; therefore, it was not easy for those within the main waiting area to get the attention of staff elsewhere within the unit.

Patients were asked to leave feedback about their experience within the unit and their scan. We were informed patients could do this either via paper questionnaire or via an electronic device. Results were collected weekly and sent to the service manager for review and feedback. There was a space on the form for patients to leave free text comments about their care. We saw evidence of this during our inspection.

The provider conducted a friends and family test (FFT) survey. The results between October 2017 and September 2018 showed out of 4099 patients that took part, 3522 patients were 'extremely likely' to recommend the service to others. There were six patients 'extremely unlikely' to recommend the service to others. The results equated to 99.4% of patients likely to recommend the service. Some of the comments received from the service included, 'all staff are helpful', 'very caring, phoned me with cancellation so I could be seen quicker than planned', and 'kind lady, thank you'.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

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

Every week, the unit was part of the host trust's female breast clinics. Female staff were used to staff this clinic. A female clinical assistant was used to position the patient inside the MRI scanner for dignity of the patient; the trainee radiographer was also female and used to assist within the MRI scanning clinic. The referral to the breast MRI scanning clinic was generally via the breast nurse at the host trust.

If the demand increased for the provision of MRI scans, the unit was able to provide an increase in their level of service using a mobile scanner. This was able to be requested and generally delivered to the unit within 24 hours.

The unit was not well signposted. It was just behind the ambulance parking bay, which made it hard to find. It was located to the side of the host trust and therefore not in an obvious location. The pavement outside the unit was uneven and had repair works being carried out. This made the area more difficult to navigate for those with mobility issues or mobility aides.

There was a ramp leading to the front door of the unit. This was also shared with the host trust. The ramp was uneven and in need of replacement to enable disabled patients to gain easier access to the unit.

Meeting people's individual needs

The service took account of patients' individual needs.

Patients attending the unit with mobility problems were able to access the service either through the main entrance which housed a ramp, or via the main hospital and then through double doors.

Within the waiting area, there was a water cooler with cups available, a radio playing and several chairs. We noted there were higher chairs with sides and coasters for patients with disabilities or specialist requirements for seating.

There was a children's table and chairs located in the corner of the room. There were also some toys available. There were colourful posters on the walls and windows which looked out onto the ambulance bay.

For patients that were bed bound or required to stay flat and on the trolley bed, the team were able to transfer the patient to an magnetic resonance (MR) safe trolley bed, that could be used to take the patient to the scanner. Once at the scanner, staff were able to use equipment to transfer the patient to the MRI scanner and then back to the trolley bed.

Information leaflets were available to explain an MRI scan to patients. These leaflets were readily available in easy read format, with a specific version for paediatric patients and a large print edition. We did not find any leaflets in alternative languages.

Patients whose first language was not English were able to request a translator. This was provided via a telephone translation service.

For patients with a hearing impairment, hearing aid loop system was available within the waiting room reception area.

Patients were able to book their appointment via an electronic system or via telephone at a time that suited them.

If a child was brought to the unit for an MRI scan, for safeguarding and security reasons, the child was placed in the paediatric assessment unit within the host trust whilst they waited for their appointment. Parents could go into the scanning room with their children if they were 'MRI safe'. This meant as long as there were no safety contraindications to the parent entering the scan room, they were welcome. This helped to relax and reassure the child having the scan, as well as providing reassurance for parents who were anxious for their children. For children, appropriate music was available whilst they were in the scanner. Play specialists were also available from the host trust on request for children undergoing a scan. Vulnerable patients were scanned at quieter times of the day to give them time and space to be able to ask questions and not be rushed.

Midday appointments were available for elderly patients and those living with dementia to suit their needs and requirements. Other patients were catered for; for example, parents requiring school time appointments were able to be accommodated, as were those with other needs and restraints.

For patients requesting the service, there was a chaperoning policy in place. This was seen during our inspection and was in date (issued September 2018). For patients attending the breast clinic, we did not find any privacy screen in use at the time of our inspection. The service did not provide a privacy screen; instead, any male colleagues left the room during the scanning process, or whilst a female patient was exposed.

Patients were offered a variety of music to listen to whilst they had their MRI scan. The machine can be very noisy and cause anxiety. This service was available to relax patients and take their mind off of the scan and their surroundings. For patients that were claustrophobic, they were able to be positioned within the scanner feet first instead, as well as being offered an eye mask to wear whilst within the machine.

Bariatric patients were not able to be scanned at this location. The provider had an open scanner at another location; they were able to refer patients to this scanner as required.

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

The lead superintendent for the unit attended the trust daily bed meeting. This was to enable the unit to plan appointments and ensure correct timing for the running of the day. There was a time slot reserved everyday between 2pm and 4pm for trust inpatients. The unit saw one to two private patients per day, and they were given a CD of their scan to take away with them for their own records.

Between July 2017 and September 2018, an average of 822 patients were scanned at the unit per month. This was an average of between 19.2 and 25.1 patients per day. Between 11 and 33 patients were rejected or refused their scan each month. An average of between 1.3% and 3.7% of patients were not scanned. Each month, between 28 and 54 patients did not arrive for their booked appointment. August 2018 was the only month that the mobile scanner had not been used in conjunction with the static scanning unit. The mobile scanner broke down for 1.3 hours in April 2018. There were no other mobile scanner breakdowns recorded. The static scanner broken down five out of 14 months, for a total of 41.8 hours, resulting in a loss of 61 patent scans.

Between June 2018 and January 2019, an average of 661 patients were scanned at the unit each month, however the target was set at an average of 537 per month. An average of 21 patients were refused or rejected every

month. An average of 30 patients per month did not attend their scan appointment. There were no scanning hours lost to breakdown of equipment with either the static or mobile scanning unit.

The waiting time for an NHS routine scan appointment was between three to four weeks; for an urgent scan, the waiting time was two weeks. Patients were booked for their scan through an electronic system that both the host trust and InHealth had access. All NHS appointments were triaged by the trust radiologist for urgency prior to the referral reaching the unit.

Between the reporting period June 2018 and January 2019, the provider recorded key performance indicators (KPIs) to show an average of 130.5 patients required a scan within one week; these patients were seen on average within 2.9 days. An average of 105.5 patients required an urgent scan (within two weeks); these patients were seen within an average of 7.2 days. The average number of patients that required a routine scan was 377.6; these patients were seen on average within 15.2 days. An average of 144.2 inpatients from the host trust received their MRI scan within an average of 1.4 days. These outcomes showed the provider exceeded their targets on all referral to treatment times within the reporting period.

Emergency patients were seen by the unit regardless of appointments booked. Emergencies were classed as suspected conditions such as cord compression. Pregnant patients were reviewed by the radiologist to see if they were safe for scanning. If the scan was agreed to go ahead, this was within agreed parameters and protocol as set out by InHealth.

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.

During 2018, the unit received three complaints. Two of these were due to communication issues with relatives. The other regarded assisting the host trust with an investigation into a complaint made to them. The two complaints regarding the unit were upheld. The complaints were logged and dated, with details of the issues that had arisen. The outcomes and any action plans were noted within the spreadsheet a RAG (red amber green) rating system to grade the seriousness of the event. The risk severity for all three incidents was labelled as minor. A full response to the complaint was dated within the spreadsheet, with learning taken from the incident noted. The evidence provided showed final responses were provided earlier than the targeted timescale of 20 working days. The average time for full response was 15.3 working days.

Formal complaints were subject to a three stage process. At the first stage, the local team attempted to find a resolution to the issue prior to escalation. If this was not able to be achieved, the complaint moved to stage two. Stage two was a review of the complaint by the internal director. If this stage was also unsuccessful, the complaint was escalated to a stage three complaint. This consisted of an external independent review, where a resolution was sought and finalised. The superintendent radiographer was the local lead for complaints.

During opening hours, an incident occurred where an intoxicated patient gained access to the MRI unit via the emergency department entrance to the unit. Staff found it challenging to remove him from the unit. This spurred on the provider's request for security to be added to the department to stop unauthorised entry to the unit for safety and security purposes

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led 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 location had a regional operations manager that was responsible for three sites, including this location. The operations manager had only been in post 12 weeks at the time of the inspection and was in the process of becoming the CQC registered manager for the location. The operations manager directly reported to the head of operations at the provider's central team.

The reporting structure had two routes for the local team. There was a clinical and administrative team reporting.

Good

Diagnostic imaging

For clinical staff, there were three senior radiographers and a graduate radiographer that reported to the superintendent radiographer. The superintendent radiographer reported directly to the operations manager. For the administrative team, two clinical assistants reported to the administrative manager, who directly reported to the operations manager. The operations manager reported directly to the head of operations. They in turn reported to the director of operations south, and finally directly to the managing director for diagnostic and integrated services.

The team had three-way meetings between the superintendent radiographer, clinical administration manager and the regional operations manager. The team were supportive of each other and staff reported managers were approachable, with easy access to their line managers.

The regional operations manager was due to start the providers leadership training programme two weeks after the inspection; the organisation was looking towards progression and succession planning.

The superintendent radiographer was the responsible person for local policies and procedures within the unit , as well as being the nominated MRI responsible person, health and safety liaison officer and incident officer. The operations manager was also a health and safety liaison officer for the three sites that were under their remit.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.

The vision for InHealth was to be the biggest provider of diagnostic imaging in the UK. This would then create opportunity, career progression and development for staff in different areas within the service.

InHealth had four values. These were trust, passion, care and fresh thinking. Trust meant being open and transparent and deliver on decisions; passion related to helping patients with those things most important to them and understanding each patients concerns and fears; care required staff to put patients first and use their feedback to improve the service provided, and fresh thinking was looking to improve the service, technology and bringing the diagnostic equipment closer to the patients' locality.

The provider hoped to improve their facilities and had plans in place with an agreed business case to replace the MRI scanner and refurbish the unit. During this time, provision had been made for the mobile MRI scanning unit to be deployed to ensure continuity of the service offered. The refurbishment of the unit was currently at business case stage with the host trust.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff we spoke with were happy working at the unit and for the provider. Staff appeared to be happy to raise concerns with management. The staff survey reported that staff did not feel they would stay with the provider on a long term basis due to the limited nature of the service provided, but they would be happy to recommend the location as a place to receive care and treatment.

Governance

The service systematically improved service quality and worked towards standards of care by creating an environment for clinical care to improve.

The governance and reporting structure was a central process. At the time of the inspection, the location did not have a registered manager. An application had been submitted by the provider and was still going through the formal process.

There was no service level agreement (SLA) between the provider and the host trust. There was a contract in place for the provision and servicing of the MRI scanner with a third party; the provider was contracted to a third party for their services. We were concerned that no SLAs were in place for the responsibility and continuity of care for patients. Without an SLA in place, there was no clear responsibility or accountability for incidents, infection prevention and control, never events, serious incidents,

crash calls and many other shared services. The provider was working on the premise that they were continuing to operate as they had started in 1999, and these processes had not been reviewed or formalised.

Incidents were reviewed by the provider's central clinical governance team; this occurred weekly. Any themes identified were acknowledged and shared with the host trust for awareness and learning purposes. There was a InHealth clinical quality sub-committee held quarterly, where incidents and learning were shared and reflected upon.

A large number of risk assessments had been conducted by the health and safety support officer on site. These ranged from needle stick injuries to moving and handling, and cleaning machinery within the scanning room. All were in date. However, where an incident had occurred and was noted, there was no follow up provided after the review date. There was no risk assessment for the security of the unit, or for non-provision of an SLA for services provided by the host trust.

The central clinical governance team produced an electronic newsletter for all staff. This was called 'CLIC' (complaints, litigation, incidents and compliments). The provider cascaded new incidents, complaints and compliments through this system to all of its employees. It contained information regarding clinical governance updates, risks and learning throughout the company, not just within local sites. The CLIC team met weekly to discuss all cases or incidents raised across all the provider sites.

We were provided with minutes for the previous three CLIC meetings dated 31 January 2019, 7 February 2019 and 14 February 2019. All meetings followed the same structure and shared governance information from across all provider sites. The CLIC had very specific terms of reference which set out its obligations and remit, including how often the terms of reference should be reviewed. At the time of our inspection, these were in date and had been reviewed in January 2019.

Within the shared scanning office, there was a policy folder containing the 12 key policies from the provider. These included adverse events, complaints, confidentiality, consent to treatment, fire safety, health and safety, infection prevention and control (IPC), patient identification, radiation protection, resuscitation, safeguarding adults and safeguarding children. Staff had signed and dated the document to state they had read and understood the policies contained within. The MRI safety policy was also seen and in date. It was due for review in December 2019.

There was an SLA in place for the provision and maintenance of equipment supplied by a third party. There was no SLA for the provision and continuity of care between the provider and the host trust.

The host trust held bimonthly meetings with the third party that held the contract for the operation of the unit, scanner and provision of InHealth staff. At the bimonthly meetings, four separate parties attended, which included the provider and the host trust; at these meetings all matters that affected operational provision of the MRI scanner were discussed and updated. This included MRI access issues, MRI scanner replacement, as well as other equipment provided by the third party at other locations within the host trust unrelated to the MRI unit. The host trust held a monthly meeting that the regional operations manager and superintendent radiographer attended. This started a month prior to our inspection.

Within the shared office, there were a number of information posters for staff regarding the Caldecott Guardian, the pathway for management of needle stick injuries, the fire escape plan and evacuation procedure.

Local rules issued by InHealth were in place for the unit, and these were issued in November 2018, with a review date for November 2019. The major accident plan was provided by the host trust. The provider had an up-to-date business continuity plan; this was due for review during June 2019, and the policy owner was the operations manager.

The manual handling policy was present at the time of our inspection. However, the date for review was December 2018, and therefore this policy was out of date. We were not provided with an updated policy.

Local team meetings were held quarterly, and included the operations manager. We reviewed the agenda, meeting minutes and action plan from two meetings; these were for April and November 2018. The November 2018 meeting did not contain an action plan or any

updates to the April meeting action plan. Both minutes had very similar information, but there was no progress update. The action plan from the April 2018 meeting did not contain review or end dates for the actions contained.

All policies and procedures were available for staff to access via the provider's intranet computer system. The unit also contained folders where specific policies were instantly available in paper format for speed and ease of reference.

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.

A risk register for the provider location was in place. It was split into many categories, such as health and safety, legal, finance, human resources, information governance, IT systems, procurement, operations and quality. We noted some of the risks did not have an owner responsible for overseeing the risk or updating the risk. For all other risks, the operations manager was the risk owner. There were many risks ongoing and outstanding on the risk register. These were monitored and updated as required. Although it was found that some risks discussed at the inspection had been updated, this was not reflected on the risk register. Some of the risks had lapsed, whilst other risks were ongoing.

We spoke with staff regarding risks and issues within the unit. The highest risk recorded was for the security of the unit. At the time of our inspection, there were three entrances/exits from the small department. One led out to the ambulance waiting bay, one led through to the emergency department and another led straight through to the radiology department. The entrance by the ambulance bay had a buzzer entry system, where a member of staff would have to allow entry. The other two entrances, which were within the host trust main building, did not have any key pad or swipe card access. Patients and staff were able to walk freely into and out of the department, and access all the offices and rooms and scanning rooms contained within the area. This had been recorded on the risk register as a concern, and the provider had been working with the host trust and their contractors to try to resolve this issue. At night and outside of normal working hours, the door to the MRI scanner was locked to prevent anyone from being able to access the machine. An agreement had been accepted by the trust and the provider to place emergency exit doors at the entrance to the emergency department entrance to the unit to prevent unauthorised access from this area. Discussions were still ongoing regarding the other entrance to the department via the radiology department.

The MRI scanner was also on the risk register. This was due to its age and usage. It was due for replacement in early 2019 and at the time of our inspection, the dates for arrival were under discussion. To mitigate this risk, a mobile MRI scanner was available to be delivered to the location within 24 hours of request. A fleet of scanners was always available to the provider.

Although no SLA was in place, the provider relied upon the host trust to provide maintenance and linen services to the unit. The host trust was also providing cleaning services and emergency response services to crash calls. The provider was not concerned that there was no SLA as they had not had any issues to date. We did ask the provider how never events and serious incidents were shared across the provider and host trust. We were informed that when previous concerns had become apparent, the provider raised the issue on their own electronic reporting system. The host trust was then informed of the incident and given a reference number for the providers system. The host trust also reported the incident on their electronic reporting system and some of the time, reported back to the provider. At times, the provider had to remind the host trust to report back to the provider their findings. In a situation where there may be difference of opinion between responsibility from an incident or event, in the absence of an SLA, we were told the provider and the trust would sit around a table and discuss the situation until they could come to a conclusion.

There was no SLA in place in the case of a deteriorating patient with the host trust. The process for patients within the department that may suffer a cardiac arrest was for the patient to be removed from the scanner immediately and taken through the double doors at the radiology entrance to the unit to the nurse's station. A call would then be put out to the trust. It was expected that the trust would respond to the call as per a normal 'crash call' at the trust. The same procedure was in use for patients within the mobile unit when it was on site. A

practice exercise had taken place to make sure all persons involved understood their role in the emergency. This was a process in place since the unit had been in operation, although the arrangements had not been written or formalised. Staff were aware of the actions to take should this scenario arise.

Audits took place at regular intervals. Health and safety audits took place every quarter, the last being in January 2019. There were 14 elements associated with this audit. These were the risk register, general office safety and ergonomics, display screen equipment, manual handling tasks, housekeeping, indoor environment, fire safety, first aid and hygiene, emergency procedures, electrical safety, hazardous substances, medical or pressurised gases, infection control and sharps. We were provided with audits for three quarters; these were April 2018, July 2018 and October 2018. April and July showed 96% compliance, October demonstrated 97% compliance and January 2019 showed 96% compliance. A third party conducted a monthly clinical audit to monitor any discrepancies in the reporting of scans and image quality for private patients. A total of 63 scans were reviewed between January 2018 and January 2019. There were two discrepancies found; one during June 2018 and another in November 2018. Both were classed as category three, 'Clinical significance of disagreement is debatable or likelihood of harm is low'.

Managing information

Electronic patient records and policies were kept secure to prevent unauthorised access to data. Authorised staff demonstrated they could be easily accessed when required.

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

All InHealth staff had an NHS pass to allow them to access to the trusts systems and electronic patient records. This was to allow staff to access patient referrals to the MRI unit and to enable scans to be uploaded directly onto the EPR.

InHealth staff also had access to their own IT systems and intranet. This was via individual passwords issued to each member of staff for safety, security, and to keep an audit trail.

Engagement

The service engaged with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

After their scan, patients were asked to complete a patient survey regarding their care and treatment. Their feedback was collected and recorded centrally. The unit conducted the friends and family test (FFT) to gain an understanding of the quality of care patients experienced at the service. This was regularly reviewed by the operations manager once per month, but outcomes were also available in real time. This was separate to the host trust's FFT.

Employees took part in the local staff survey. The last survey conducted by the provider was in December 2017 and the results were published in January 2018. A total of nine members of staff took part; the provider scored 100% in four questions. These were: 'patient safety is a key priority', 'my manager is an effective leader of my team', 'I have the equipment to do my job properly' and 'I know what is expected of me at work'. The lowest score achieved was 56% for 'I would still like to be working at InHealth in two years' time'. This may have been due to longer working hours in comparison to similar services. The survey was split into four areas, although it was not clear how these were aligned. Each question showed the comparison against the provider-wide survey and local results, the desired position, actions to be taken, who was responsible, and by when. Although there were actions in place to address issues, there were no updates as to actions taken recorded, and none were marked as complete.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

The provider had real time reports sent to the operations manager to show the locations KPIs and FFT results. They were able to keep up to date immediately with the findings and implement change as it was required.

The service had put business case forward to have the scanner replaced and the unit refurbished. The new scanner business case had been successful with the third

party that leased and serviced the MRI scanning machine. The new scanner was due to be delivered early in 2019. The business case to refurbish the unit was sitting with the host trust as they shared the area with the provider. The business case was pending and would need to be coordinated with the delivery of the new MRI scanner.

A business case was put forward by the provider to have secure locking put on the entrance/exit doors to the unit. They felt this would make the unit less accessible to those unauthorised to access the department and make the environment safer for staff and patients alike. The provider was waiting to hear from the host trust. However one of the entrance doors had been agreed to be changed by the host trust to an emergency exit style door within two weeks of our inspection.

The mobile MRI scanner was available with approximately 24 hours' notice to cope with demand and any equipment failure. This mobile scanner was parked outside the static unit and was easily accessible to staff and patients.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure the safety of all patients and staff by ensuring there is adequate control measures on the doors giving access to the department.
- The provider should ensure access to the scanning viewing room/office is restricted whilst the scanner is in use. This is to ensure patient privacy and dignity, and to ensure the radiographer is not distracted during a scan.
- The provider should ensure there is a service level agreement between all parties providing services, including the host trust, setting out each parties roles and responsibilities and duty of care to the patient.