

Inhealth Diagnostic Centre

Quality Report

688 South Fifth Street
Milton Keynes
Buckinghamshire
MK9 2FX

Tel: 01908 203700

Website: www.InHealthgroup.com/location/InHealth-diagnostic-centre-milton-keynes/

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

Ratings

Overall rating for this location

Good



Are services safe?

Good



Are services effective?

Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

InHealth Diagnostic Centre is operated by InHealth Limited. The service provides diagnostic imaging services to the local community. It is a stand-alone purpose-built diagnostic screening facility.

InHealth was established 25 years ago to meet some of the health economy's most pressing challenges – reducing waiting times, speeding up diagnoses, saving money, improving patient pathways and enhancing the overall patient experience. Efficiency models from manufacturing programmes were adapted to develop healthcare services focused on continuous quality improvement. The organisation was successful in winning contracts and has grown due to its access to capital for investment, its ability to design and adapt healthcare solutions to meet changing demands, demonstrate value for money and to work collaboratively with its NHS and private sector partners.

Milton Keynes InHealth Diagnostic Centre opened in 2010. The centre provides magnetic resonance imaging (MRI) scans, computed tomography scan (CT) scans, dual-energy X-ray absorptiometry (DEXA) scans and ultrasound for both NHS and private patients. The unit is registered with the CQC to undertake the regulated activities of diagnostic and screening procedures and treatment of disease, disorder or injury. The site provides a service for adult patients only (aged 18 and above). The site operates 7 days a week between the hours of 8am and 8pm.

Milton Keynes InHealth Diagnostic Centre is based in a double storey building in the centre of Milton Keynes. The service has one ultrasound scanner, a CT scanner a MRI Scanner and a DEXA machine. The service provides contracted imaging to NHS funded patients. Each year, the local hospital trust commission approximately 500 MRI scans. The local clinical commissioning group commissions approximately 5000 musculoskeletal MRI scans and 930 DEXA scans and a local private provider commissions approximately 200 musculoskeletal MRI scans. The service also carried out CT scans and non MSK MRI for a local private provider.

The service had out sourced image reporting to a third party. Most reporting was completed locally by in-house radiologists. However, the service outsourced to ensure they kept within the tight key performance indicators for reporting turnaround times and national targets when the providers' radiologists did not have capacity.

A review was carried out at the location to assess compliance with the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER17) in May 2018. Overall compliance with IRR17 and IRMER was good. The Imaging Services Manager and radiology staff were aware of the local rules and procedures and these documents are reviewed on a regular basis. Most of the recommendations following this audit related to updating the current documentation to comply with the implementation of the new IRR17 and IRMER regulations. Some minor changes to the procedures were recommended to reflect local arrangements.

The service had not been the subject of an external investigation between August 2017 and August 2018.

We inspected diagnostic imaging services at this location.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 11 September 2018

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.

The service provided at this location was diagnostic and screening procedures and treatment of disease, disorder or injury.

Summary of findings

Services we rate

We previously did not have the authority to rate this service. We rated it as good overall.

We found the following areas of good practice:

- Staff received effective training in the safety systems, processes and practices.
- There was evidence that staff received feedback from incident reporting processes.
- There were sufficient numbers of staff with the necessary skills, experience Patients had their needs assessed and their care and treatment was planned and delivered in line with evidence-based guidance, standards and best practice and qualifications to meet patients' needs.
- Staff felt supported to do their job and developed in their roles.
- There was evidence of regular team meetings.
- Staff were caring, kind and engaged with patients.
- We observed a focused and individual approach to patient care.
- Information about the needs of the local population was used to inform how services were planned and delivered.
- Leaders had the skills, knowledge, experience and integrity needed both, when they were appointed and on an ongoing basis.

However, we found areas of practice that the service needed to improve:

- At the time of inspection, it was not clear if staff were aware of the changes made by the introduction of the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER17).
- We did not see evidence locally of a capital replacement plan for the MRI scanner, the CT scanner, the DEXA Scanner and the ultrasound machine. All the diagnostic equipment on site was between eight and twelve years old and heading towards being at the end of their working lives. While the service had service level agreement to ensure all pieces of equipment were regularly checked and serviced, at local level, the service was not aware of a plan to replace the equipment. This issue was not on the local risk register.
- There was limited storage available for stock items in the CT room.

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.

Heidi Smoult

Deputy Chief Inspector of Hospitals (Central)

Summary of findings

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Good



Inhealth Diagnostic Centre

Services we looked at

Diagnostic Imaging and Endoscopy Services

Summary of this inspection

Background to Inhealth Diagnostic Centre

InHealth Diagnostic Centre is operated by InHealth Limited. The head office location is at High Wycombe, Buckinghamshire. InHealth was established over 25 years ago following an aspiration to meet some of the health economy's most pressing challenges – reducing waiting times, speeding up diagnoses, saving money, improving patient pathways and enhancing the overall patient experience. Efficiency models from manufacturing programmes were adapted to develop healthcare services focussed on continuous quality improvement. The organisation was successful in winning contracts and has grown due to its access to capital for investment, its ability to design and adapt healthcare solutions to meet changing demands, demonstrate value for money and to work collaboratively with its NHS and private sector partners.

Milton Keynes InHealth Diagnostic Centre opened in 2010. The centre provides MRI, CT, DEXA and Ultrasound for both NHS and private patients. The unit is registered with the CQC to undertake the regulated activities of diagnostic and screening procedures and treatment of disease, disorder or injury. The site provides a service for adult patients only. The site operates seven days a week between the hours of 8am and 8pm. The service currently has a registered manager (RM) in post, however, there was no RM in post between November 2016 and January 2018 following voluntary deregistering of the previous RM.

Our inspection team

The team comprised a CQC lead inspector who had completed the single speciality diagnostic imaging training and a specialist advisor. The inspection team was overseen by Phil Terry, Inspection Manager and Bernadette Hanney Head of Hospital inspection.

Information about Inhealth Diagnostic Centre

The location was registered to provide the following regulated activities:

- Diagnostic and screening procedures.
- Treatment of disease, disorder or injury.

The Diagnostic Centre undertakes magnetic resonance imaging (MRI) scans, computed tomography scan (CT) scans, dual-energy X-ray absorptiometry (DEXA) scans and ultra sound scans on patients to diagnose disease, disorder and injury. All staff employed at the unit are employed by InHealth. The site operates seven days a week between the hours of 8am and 8pm. No clinical emergency patients or persons under the age of 18 are scanned within the service, this service does not care for patients under the age of 18.

Milton Keynes InHealth Diagnostic Centre is an independent owned and run double storey building within central Milton Keynes. The unit has two entrances, one located at the back of the building which is controlled through fob and key access. The other is through the main front entrance within the reception area. The ground floor consists a waiting area with reception desk leading to admin office and mixed sex toilet and the controlled access area. The control access area, accessed through a secured fob access door comprises a sub waiting area, two clinical ultrasound rooms, one which is primarily used for patient preparation and observations and the other as a clinical ultrasound room, which houses the ultrasound scanner. There is also a reporting room, secure store cupboard a mixed sex toilet and two changing areas, one male, one

Summary of this inspection

female. There is a CT room located directly off the sub waiting area which is secured by hazard barrier and warning signs and lights. The CT room houses a 124 slice CT scanner. The MR room and shared control area to both CT and MR are located through a further secure access door controlled by security fob. Within this door there is another sub waiting area and access to the control room and MRI scan room. The control room is the operators' area which provides control to both CT and MRI rooms. There is also a plant room on the ground floor. The MR room houses a single 1.5T MRI Scanner. The second floor of the building comprises a waiting area, large meeting room, secure supplies cupboard and four other clinical rooms/offices. There is also a DEXA scan room which houses a DEXA machine and a mixed sex toilet. There is a further plant/storage secure room located off this waiting area. There is also access through a further door to a designated staff room with kitchen facilities also two separate changing areas and a staff toilet.

During the inspection, we visited the registered location in Milton Keynes. We spoke with eight staff including, administration staff, radiographers, and senior manager. We observed three MRI scans, one CT scan and engaged with patients and relatives during these procedures. During our inspection, we reviewed five patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

The service was registered with the CQC in February 2013. We inspected the service in January 2014. This inspection was carried out under the previous inspection methodology. It was a routine inspection. We inspected the following standards, this is what we found:

- Respecting and involving people who use services: Met this standard.
- Care and welfare of people who use services: Met this standard.
- Safety, availability and suitability of equipment: Met this standard.
- Requirements relating to workers: Met this standard.
- Complaints: Met this standard.

Activity (August 2017 to August 2018)

- There were 5,700 MRI scans performed at the service between August 2017 to August 2018; 5,000 of these (88%) were muscular skeletal (MSK) MRI Scans (Adult) commissioned by a local clinical commissioning group and 500 (9%) were completed as part of a NHS contract and 200 (3%) were completed for another private provider.
- There were 930 DEXA scans commissioned by a local clinical commissioning group carried out in the service between August 2017 to August 2018. 900 were completed as part of a NHS contract and 30 were private patients.
- 877 CT scans were completed between August 2017 to August 2018. 223 were completed as part of a NHS contract and 654 were private patients.
- 96 ultrasound scans were completed between August 2017 to August 2018. All were private patients
- The service did not use any medicines and therefore they did not have an accountable officer for controlled drugs (CDs).

Track record on safety

- No never events.
- No serious incidents.
- No incidences of healthcare acquired Meticillin-resistant Staphylococcus aureus (MRSA).
- No incidences of healthcare acquired Meticillin-sensitive Staphylococcus aureus (MSSA).
- No incidences of healthcare acquired Clostridium difficile (C. difficile).
- No incidences of healthcare acquired Escherichia coli (E-Coli).
- The service had received ten complaints between September 2017 and September 2018, all of which were upheld.

Services accredited by a national body:

InHealth has three accreditations by national bodies:

- Investors in People (Gold award), awarded December 2016, date of renewal: December 2019.
- ISO 9001: Quality management systems standards, awarded 2015, Date of renewal: December 2019.

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- ISO 27001: International Organization for Standardization - information security management awarded 2013, Date of renewal: December 2019.

Services provided under service level agreement:

- Clinical and or non-clinical waste removal.
- Laboratory services.
- Interpreting services.
- Maintenance of medical equipment.
- Laundry

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as good because:

- Staff received effective training in the safety systems, processes and practices.
- Staff working with radiation were provided with appropriate training in the regulations, radiation risks, and use of radiation.
- There were safeguarding systems, processes and practices essential to keep people safe identified, put in place and communicated to staff.
- Standards of cleanliness and hygiene were maintained.
- Staff compliant with best practice regarding hand hygiene.
- The design, maintenance and use of facilities and premises were appropriate. Maintenance and use of equipment was effective.
- Radiation warning signs and lights were correctly located outside all clinical diagnostic imaging areas.
- There were comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance. There was a pathway for unexpected urgent clinical findings.
- The service ensured the World Health Organisation (WHO) Surgical Safety Checklist for radiological interventions was effectively used when carrying out interventional radiology.
- There were sufficient numbers of staff with the necessary skills, experience and qualifications to meet patients' needs.
- Patients' individual care records were written and managed in a way that protected patients from avoidable harm.
- Arrangements were in place for managing medicines, medical gases and contrast media that protected patients from avoidable harm.

Good



Are services effective?

We currently do not rate effective, we found:

- Patients had their needs assessed and their care and treatment was planned and delivered in line with evidence-based guidance, standards and best practice.
- Information about the outcomes of people's care and treatment was routinely collected and monitored.
- Staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, took on new responsibilities and on a continual basis.

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- All necessary staff, including those in different teams and services were involved in assessing, planning and delivering people's care and treatment.
- Information leaflets such as understanding your CT scan, understanding your MRI scan were sent to patients with their appointment letters and were available in the waiting rooms.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.

Are services caring?

We rated caring as good because:

- We observed all staff treating patients with dignity, kindness, compassion, courtesy and respect.
- Staff understood the impact that a patient's care, treatment or condition had on their wellbeing and on their relatives, both emotionally and socially.
- We observed staff communicating with patients so that they understood their care, treatment and condition.
- Staff recognised when patients and those close to them need additional support to help them understand and be involved in their care and treatment and enable them to access this.

Good



Are services responsive?

We rated responsive as good because:

- Information about the needs of the local population was used to inform how services were planned and delivered.
- Services were planned to take account of the needs of different people.
- Patients had timely access to scanning.
- Patient we spoke with knew how to make a complaint or raise concerns.

Good



Are services well-led?

We rated well-led as good because:

- Leaders had the skills, knowledge, experience and integrity needed both, when they were appointed and on an ongoing basis.
- The service had a clear vision and a set of values, with quality and safety the top priority. InHealth had four clear values: Care, Trust, Passion and Fresh thinking.
- Staff felt respected and valued. Staff told us they felt supported, respected and valued by the organisation.

Good



Summary of this inspection

- There was an effective governance framework to support the delivery of the strategy and good quality care.
- There was a risk assessment system in place locally with a process of escalation onto the corporate risk register.
- Electronic patient records were kept secure to prevent unauthorised access to data however authorised staff demonstrated they could be easily accessed when required.
- Patients' views and experiences were gathered and acted on to shape and improve the services and culture.
- Staff told us they felt actively engaged, their views were reflected in the planning and delivery of services and in shaping the culture
- Staff could provide examples of improvements and changes made to processes based on patient feedback, incidents and staff suggestion.

However,

- It was not clear if staff were aware of the changes made by the introduction of the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER17) which had been introduced in February 2018.
- We were aware all the diagnostic equipment on site was between eight and twelve years old and heading towards being at the end of their working lives. While the service had service level agreement to ensure all pieces of equipment were regularly checked and serviced, the service did not have a plan to replace the equipment. This was not on the local risk register.





Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic Imaging and Endoscopy Services	Good	N/A	Good	Good	Good	Good
Overall	Good	N/A	Good	Good	Good	Good

Diagnostic Imaging and Endoscopy Services

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Good 

Summary of findings

We found the following areas of good practice:

- Staff received effective training in the safety systems, processes and practices.
- There was evidence that staff received feedback from incident reporting processes.
- There were sufficient numbers of staff with the necessary skills, experience Patients had their needs assessed and their care and treatment was planned and delivered in line with evidence-based guidance, standards and best practice and qualifications to meet patients' needs.
- Staff felt supported to do their job and developed in their roles.
- There was evidence of regular team meetings.
- Staff were caring, kind and engaged with patients.
- We observed a focused and individual approach to patient care.
- Information about the needs of the local population was used to inform how services were planned and delivered.
- Leaders had the skills, knowledge, experience and integrity needed both, when they were appointed and on an ongoing basis.

However, we found areas of practice that the service needed to improve:

- At the time of inspection, it was not clear if staff were aware of the changes made by the introduction of the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER17).
- We did not see evidence locally of a capital replacement plan for the MRI scanner, the CT scanner, the DEXA Scanner and the ultrasound machine. All the diagnostic equipment on site was between eight and twelve years old and heading towards being at the end of their working lives. While the service had service level agreement to ensure all pieces of equipment were regularly checked and serviced, at local level, the service was not aware of a plan to replace the equipment. This issue was not on the local risk register.
- There was limited storage available for stock items in the CT room.

Diagnostic Imaging and Endoscopy Services

Are diagnostic imaging and endoscopy services safe?

Good 

We rated this service as **good**.

Mandatory training

- Staff received effective mandatory training in the safety systems, processes and practices. At the time of inspection, 96% of staff were compliant with their mandatory training. Training was delivered in either a face to face format or as an e-learning module. A contemporaneous training record was available for all staff and was reviewed by their line manager
- Mandatory training subjects included:
 - Fire safety and evacuation
 - Health and safety for healthcare
 - Equality and diversity
 - Infection prevention and control
 - Moving and handling objects and people/patients
 - Customer care and complaints
 - Basic life support (BLS) and data security awareness.
- At the time of inspection, BLS compliance for the service was 78%. However, of the six staff showing as non-compliant, four had training booked. Two of the staff's training had expired. There was a plan in place to ensure staff attended their expired training.
- It was a requirement for all qualified clinical staff to have Immediate life support (ILS) training. At the time of inspection, ILS training compliance was 86%. However, both staff who were showing as non-compliant had training booked. There was a system in place to ensure there was always staff members on duty with the correct level of resuscitation training.
- Bank staff used within the department were required to undertake the same mandatory training as substantive InHealth staff members. This could be

provided by evidence from another source for example evidence of up to date training from their main employer, or they were able to enrol for a mandatory training course run by InHealth.

Safeguarding

- There were systems, processes and practices essential to keep people safe identified, put in place and communicated to staff.
- The lead for safeguarding was the nominated individual who was trained to level four.
- Staff were trained to recognise adults at risk and were supported with an effective safeguarding adults' policy in place that reflect relevant legislation and local requirements. Staff we spoke with demonstrated they understood their responsibilities and adhered to safeguarding policies and procedures.
- At the time of the inspection, all staff had been trained safeguarding children level one and two and safeguarding adults. The unit did not treat patients who were under the age of 18. However, all staff had received training in safeguarding children and young people level two, as it was possible children would be present with patients and relatives. This met intercollegiate guidance: Safeguarding Children and Young People: Roles and competencies for Health Care Staff (March 2014). Guidance states all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers should be trained to level two.
- Contact numbers for local adult and child safeguarding referrals were displayed in the magnetic resonance imaging (MRI) / computed tomography scan (CT) control room.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were maintained. InHealth Limited had infection prevention and control (IPC) policies and procedures in place which provided staff with guidance on appropriate IPC practice in for example, communicable diseases and isolation.
- There had been no instances of healthcare acquired infections from September 2017 and September 2018.

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- All areas we visited on the day of inspection were visibly clean and generally clutter free. However, there was limited storage available in the CT room. There was a box on the floor behind the CT machine, storing consumable items. Following the inspection, the provider informed us shelving units had now been installed to prevent recurrence of this problem.
- The unit team cleaned the scanning rooms at the end of each day. Cleaning was recorded on a daily check sheet which was reviewed by the unit superintendent each week.
- We observed staff to be compliant with best practice regarding hand hygiene, and staff were noted to be bare below the elbow. There was access to hand washing facilities. We observed staff washing their hands using correct hand hygiene techniques before, during and after patient contact. Patients told us staff always washed their hands prior to attending to them. Hand sanitiser gels were available at the entrances to all rooms. Information charts about hand hygiene were displayed throughout the clinical room we visited.
- Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene.' These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene to reduce risk of cross contamination between patients. Results for April 2018 to June 2018 showed a compliance rate of 85%. Hand hygiene results were communicated to staff through their staff meetings and through email.
- A supply of personal protective equipment (PPE), which included gloves and aprons were available and accessible in all clinical areas. During this inspection we observed all staff to be using PPE appropriately.
- Staff followed manufacturer's and IPC guidance for routine disinfection. Staff cleaned medical devices, including MRI coils between each patient and at the end of each day. We observed staff cleaning equipment and machines during this inspection.
- Staff adhered to National Institute for Health and Care Excellence (NICE) QS61 Statement 5, (People who

need a vascular access device have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the device and its removal).

- Staff were trained in cannulation and explained to us the need to monitor cannula sites for extravasation. Staff told us about the process, they removed the cannula promptly, post scan and disposed of it correctly in a contaminated sharps container. Cannulas were left in situ for 10 minutes after injection of contrast in case the patient should experience a delayed contrast reaction. We observed safe practice.
- Sharps disposal bins (secure boxes for disposing of used needles) were located as appropriate across the service which ensured the safe disposal of sharps, for example needles. They were all clean and not overfilled. Labels were correctly completed to inform staff when the sharps disposal bin had been opened.

Environment and equipment

- The design, maintenance and use of facilities and premises were appropriate. The layout of the unit was compatible with health building note (HBN06) guidance. Health Building Notes give best practice guidance on the design and planning of new healthcare buildings and on the adaptation/ extension of existing facilities
- The building had clear signage and visual prompts to assist with patients and visitors attending the service. Access to clinical areas were secure with doors opened through a key fob or entry system, managed by the reception staff.
- The building had two entrances, one located at the back of the building which was controlled through fob and key access. The other was through the main front entrance with a reception area. Parking to the front of the building was available but at a cost to the patients. Three hours, free parking was available within a short walk from the building. The reception area and waiting areas were clean accessible.
- The service had a 124 slice CT scanner, a single 1.5T MRI Scanner, a DEXA machine and an ultrasound scanner. A control/observation area allowed visibility of all patients during CT and MRI scans. Fringe fields were displayed (The fringe field is the peripheral

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magnetic field outside of the magnet core. Depending on the design of the magnet and the room a moderately large fringe field may extend for several meters around, above, and below an MR scanner). We observed there was sufficient space around the scanner for staff to move and for scans to be carried out safely. Patients had access to an emergency call buzzer, ear plugs and defenders during scanning, music could be played. A microphone allowed contact between the radiographer and the patient at all times.

- The room was equipped with an oxygen monitor, as recommended in HBN06-13.64, to ensure that any helium gas leaking (quench) from the cryogenic Dewar (this is a specialised type of vacuum flask used for storing cryogenics such as liquid nitrogen or liquid helium), is not moving into the examination room, thus displacing the oxygen and compromising patient safety. In addition, the room was fitted with an emergency quench switch which was protected against accidental use. The magnet was also fitted with emergency “off” switches, which suspend scanning and switch off power to the magnet sub-system but will not quench the magnet. Staff we spoke with were fully aware of the emergency nature of a quench situation.
- An MRI safe wheelchair and trolley were available in the scanning room should they be required to transfer a patient in the event of an emergency.
- Patient weighing scales were available in the unit and we saw where they had been appropriately service tested.
- Resuscitation equipment, for use in an emergency was accessible in an emergency. The resuscitation trolley was visibly clean and safe for use. Daily and weekly checks carried out, demonstrated the equipment was safe and fit for use. There were procedures in place for removal of a collapsed patient and we reviewed evidence of evacuation practices performed twice yearly.
- Maintenance and use of equipment was effective. We looked at ten items of equipment, they all had a sticker indicating when they had been last serviced

and when the next service was due. Equipment we looked at had an up to date service record which provided information on when an item was due to be serviced.

- We saw radiation warning signs and lights were correctly located outside all clinical diagnostic imaging areas. Signs on all doors explained the magnet strength and safety rules.
- All relevant MRI equipment was labelled in line with medicines and healthcare products regulatory agency (MHRA) recommendations e.g. MR Safe, MR Conditional, MR Unsafe. For example, in the assessment area all equipment was labelled MR unsafe.
- There were appropriate arrangements for managing waste and clinical specimens. Dirty linen and equipment was kept separately. Clinical waste bins were foot operated and once bags were full, they were removed to a secured waste area.
- Chemical products deemed as hazardous to health were in locked cupboards or rooms that were only accessible to authorised staff.
- Spills kits, for the safe cleaning of body fluids, such as blood were readily available in each clinical area we visited.
- Emergency pull cords were available in areas where patients were left alone, such as toilets and changing areas. Call bells were available within the MRI scanner which patients could press if they wanted the scan to stop.
- Waste was handled and disposed of in a way that kept people safe. Staff used the correct system to handle and sort different types of waste and these were labelled appropriately.

Assessing and responding to patient risk

- There were comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance. For example, we saw evidence of a magnetic resonance imaging patient safety questionnaire. Risks were managed positively and updated appropriately where a change in the patient’s condition was required for example managing the claustrophobic patient.

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- Staff used The Society of Radiographers (SoR) “Paused and Checked” system. To reduce the risk of referrer error. Pause and Check consisted of the three-point demographic checks to correctly identify the patient, as well as checking with the patient the site/side to be imaged, the existence of previous imaging and for the operator to ensure that the correct imaging modality is used.
- Clinical staff told us they felt confident to identify and respond appropriately to changing risks to people who use services, including deteriorating health and wellbeing or medical emergencies. All clinical staff had received immediate life support training. There were clear pathways and processes for staff to assess people using services in radiology departments who were clinically unwell and need hospital admission. For example, the InHealth routine CT and MRI guidance policies were available to guide staff in referring patients to an emergency department.
- A doctor was on site at all times cardiac scans or contrast materials were being used. Patients that became unwell in the unit would be initially reviewed on site by the doctor if attending for a CT cardiac scan or referred to their GP. However, if the patient required more urgent treatment they would call 999.
- The service ensured that the ‘requesting’ of an MRI was only made by staff in accordance with MHRA guidance (Safety Guidelines for Magnetic Resonance Imaging Equipment in Clinical Use) (2015). The referral forms included patient identification, contact details, clinical history and examination requested, and details of the referring clinician/practitioner.
- Signs were located in the waiting areas highlighting the contraindications to MRI including pacemakers. Signs also informed patients and visitors of the magnet strength and that it was always on.
- There was a pathway for unexpected urgent clinical findings. Staff we spoke with explained the processes to escalate unexpected or significant findings both at the examination and upon reporting. These were in line with InHealth routine MRI and CT guidance policies. For example, if the patient needed urgent report and an attendance at accident and emergency (A&E) following scan findings. An urgent report request was sent to the reporting provider. Once the report was received (within 24 hours), The urgent report was sent to the referrer, the administration team contact the referrer to confirm receipt. If the patient was a private patient, the reporting radiologist was contacted by a member of staff to advise them of the urgent report to ensure it received prompt attention. If at time of scan, the radiographers thought the patient needed urgent medical attention, the patient was advised to attend A&E. All images would be sent to A&E urgently through the image exchange portal to assist in patient management.
- No patients who were transferred from the location to another health care provider from September 2017 and September 2018.
- Radiation risks to patients were managed in line with guidance from the International Atomic Energy Agency (IAEA) Applying Radiation Safety Standards in diagnostic radiology and interventional procedures using x-rays. The Committee on Medical Aspects of Radiation in the Environment (COMARE 16th report): Review of radiation dose issues from the use of CT published 14 August 2014
- The service ensured that women (including patients and staff) who were or may be pregnant always inform a member of staff before they were exposed to any radiation in accordance with IRMER.
- We saw evidence the potential risks of intravascular administration of contrast were weighed against the potential benefits. Systems were in place including trained individuals that were able to recognise and treat severe contrast reactions, including anaphylaxis. At the service this role was fulfilled by radiographer who had been appropriately trained. A doctor was always present in the location when contrast was administered.
- There were local policies in place for the risk assessment and prevention of contrast-induced nephropathy. There were in keeping with NICE AKI (acute kidney injury) guidelines and the Royal College of Radiologists (RCR) standards for intravascular contrast agent administration.
- There was a policy for documenting, investigating, making a referral to a specialist drug allergy service and advising the patient in cases where significant suspected contrast reactions are suspected.

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- The service ensured the WHO Surgical Safety Checklist for radiological interventions was effectively used when carrying out interventional radiology, it had been adapted to fit local practice.
- The service had named staff fulfilling the essential roles of radiation protection advisor, medical physics expert, radiation protection supervisor, senior radiologist and infection control lead. The service had appointed a radiation protection supervisor (RPS). Staff said the radiation protection advisor (RPA) and the medical physics expert (MPE) were readily accessible online or through the telephone for providing radiation advice.
- There were local rules (IRR) and employer's procedures in place (IRMER) which protect staff and patients from ionising radiation.
- A review was carried out at the location to assess compliance with the (IRR17) and the (IRMER17) in May 2018. Overall good compliance was seen with IRR17 and IRMER. The Imaging Services Manager and radiology staff were aware of the local rules and procedures and these documents were reviewed on a regular basis. Most of the recommendations following this audit related to updating the current documentation to comply with the implementation of the new IRR17 and IRMER regulations. Some minor changes to the procedures were recommended to reflect local arrangements.
- Staff were provided with a debrief, or other support after involvement in any incident/accidents.

Staffing

Radiography staffing

- There were sufficient numbers of staff with the necessary skills, experience and qualifications to meet patients' needs. An InHealth staffing policy was in place, this enabled the unit to effectively maintain safe staffing levels and ensured there were sufficient numbers of suitably qualified, skilled staff to carry out daily tasks. The policy and procedure outlined how the headcount (actual number of staff on duty) and full time equivalent (FTE) numbers were to be calculated and managed at unit level.
- The staffing policy ensured the service operated safely and effectively, with the appropriate number of staff

and correct skill mix levels required to facilitate safe and compassionate care. The service used a purpose built 'staffing calculator', designed to take account of expected, and a degree of unexpected, absences; They used this to ensure sufficient staff were available across all operational periods. Required staffing levels were calculated using core service information including:

- Operational hours.
- Patient complexity and service specifications.
- Physical layout and design of facility/service -Expected activities.
- Training requirements.
- The service employed two whole time equivalent (WTE) superintendent radiographers five and half WTE senior radiographers, two WTE radiographers and six WTE radiographic assistants.
- Since August 2017, one WTE senior radiographer had left the service, one WTE senior radiographer has joined the service. Four administrators had left the service, three had joined the service. One senior administrator had left the service.
- At the time of inspection, the service had the following vacancies:
 - One WTE senior radiographer.
 - One senior administrator.
 - One administrator (fixed term to cover maternity leave).
- The service had used bank staff to cover times of staff shortage. Between June 2018 and August 2018, one senior radiographer shift, 51 radiographic assistant shifts and 70 administrator shifts were covered by bank staff. 36 senior radiographer shifts were covered by InHealth senior radiographers brought in from other locations.
- Between June 2017 and August 2018, the average sickness rate was reported as 17.8% for senior radiographers and 2.2% for administrators.
- The unit manager was also the manager for another InHealth MRI unit locally and could flex regular

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radiographer cover across both units to cover days off and leave. This ensured staff continuity and familiarity with the unit. Most staff rotated between both services.

- All staff we spoke with felt that staffing was managed appropriately. We saw no appointments had been cancelled as a result of staffing issues between August 2017 and August 2018.
- Radiographers told us they could contact a manager for advice at any time. There was an on-call provision the superintends and registered manger shared the on-call responsibilities.
- While the service had not used agency staff within the service between August 2017 and August 2018, the service had a policy in place to support agency staff. Staff told us, on first day within the department, all new staff, including bank, agency staff and contractors were taken through the companies 'Induction Checklist. They were also asked to complete a local induction which detailed the department, emergency procedures, checks that were completed on a daily/weekly basis, local and companywide policies and procedures, local rules and guidance and any access to system which may be required should the staff member be working with the unit for a number of weeks. The unit superintendent or Imaging services manager provided them with a tour of the department. The staff member was given relevant contact numbers which may be required during a normal working day and emergency contact details of the imaging service manager should they not be on site. The agency staff member would always be working with an experienced member of InHealth staff.
- Prior to undertaking any shifts independently, the agency or bank staff member would have to successfully complete a period of induction. Prior to any agency staff member being employed to assist in an uncovered shift, the imaging services manager for the unit reviewed the candidates references from previous employers or site they have worked as agency and proof of all compulsory mandatory training relevant to the position they were required to fill and previous equipment experience to establish suitability.

- Each service was managed by an experienced operational manager, supported by regional management and central support functions, to maintain 24-hour accountability for safe and appropriate staffing levels.
- Managers were empowered to 'flex' staffing numbers to meet operational requirements.
- The service had a robust 'lone working' policy and risk assessment process.
- The service had a comprehensive business continuity plan detailing mitigation plans in the event of unexpected staff shortages or unavailability.
- The staffing team for Milton Keynes InHealth Diagnostic Centre also covered Milton Keynes Hospital MRI Centre.

Medical staffing

The service did not employ any medical staff, however consultants providing cardiac CT, DEXA and ultrasound scans worked under practising privileges. The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice, or within the provision of community services. All consultants worked for the local NHS trust.

Records

- Patients' individual care records were written and managed in a way that protected patients from avoidable harm. We reviewed six patient records. Records were accurate, complete, legible, up to date and stored securely. Records were electronic and available for access by staff. Paper records such as paper referrals were shredded as per policy once the information was uploaded.
- The Radiology Information System and Picture Archiving and Communication System used by the service was secure and password protected. Each staff member had their own personally identifiable password.
- Medical records generated by staff holding practising privileges were available to staff and other providers who may be required to provide care or treatment to the patient.

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- The service provided electronic access to diagnostic results to the referring hospital and could share information electronically if referring to an A&E for emergency review.
- The quality of images was peer reviewed locally and quality assured on a corporate level. Any deficiencies in images were highlighted to the member of staff for their learning. However, this was very rare and the services re-scanning rate was negligible.
- The provider communicated with the patient's GP when necessary for example, following unexpected urgent clinical findings. If the patient needed urgent report and an attendance at A&E following scan findings, an urgent report request was sent to the reporting provider. Once the report was received (within 24 hours), an email was sent to the agreed staff within the referring service to highlight an urgent report. In addition to this, InHealth's picture archiving and communication system (PACS) team also contacted the referrer by phone to inform them an urgent report had been sent and the person who was spoken to was recorded on the database.
- A key information audit was carried out on the referrals bimonthly. This was to ensure necessary information was obtained. This internal audit was carried out to establish if any further training was required. Result feedback was given to staff.

Medicines

- Arrangements were in place for managing medicines, medical gases and contrast media that protected patients from avoidable harm. (This includes obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal.)
- Medicines, including intravenous fluids, were stored securely. Medicines requiring storage within a designated room were stored at the correct temperatures, in line with the manufacturers' recommendations, to ensure they would be fit for use.
- Room temperatures were recorded as part of the daily checks by staff. The temperature records showed temperatures had been checked daily and were within the required range. Staff knew what to do if the temperatures were not within the required range. This would be escalated to the unit manager, or manager on call if out of hours and the service company would be contacted. Staff understood the process for reducing the life of medications if temperature had not been maintained.
- No controlled drugs (medicines) were stored and/or administered as part of the services provided in this unit. Controlled medicines are classified (by law) based on their benefit when used in medical treatment and their harm if misused. The Misuse of Drugs Regulations include five schedules that classify all controlled medicines and drugs.
- Patient Group Directions (PGDs) were used in the service. PGD's were in place for all commonly used Gadolinium based contrast agents. PGDs were also in place for intravenous injections and administration of Oxygen.
- The Society of Radiographers (SoR) recommended "Paused and Checked" system was used to check medications prior to administration.
- Staff were trained on the safe administration of contrast media including intravenous contrast (IC). We reviewed staff competency files and saw all staff had received this training. We observed one patient receiving IC during our inspection, their allergies were documented and checked on arrival in the unit.
- Emergency medicines were available in the event of an anaphylactic reaction. These were in date.
- Patients were given a patient information card post scan which documented which medications they had been given. This included contrast media, bowel preparations and anti-spasmodics. The card directed patients to seek advice from their GP or A&E if feeling unwell after leaving the unit and explained they should show the information regarding what they had received.
- The pharmacy team at the local acute trust was available for assistance and advice locally if required. InHealth had a consultant pharmacist who issued guidance and support at a corporate level and worked collaboratively with the InHealth clinical quality team on all issues related to medicines' management. Replacement medication and disposal was provided by this service.

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Incidents

- There were no never events reported for the service from September 2017 to September 2018. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- There were no serious incidents reported for the service from September 2017 to September 2018 as defined by the NHS improvement. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.
- Senior staff were aware of the requirements for reporting serious incidents to the CQC using the statutory notification route if this met the criteria, under Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.
- There were local procedures in place to ensure, that radiation incidents were fed into risk management and that exposures ‘much greater than intended’, were notified to CQC IR(ME)R team under IR(ME)R or to Health and Safety Executive (HSE) under IRR99 requirements.
- There were no IRMER/IRR reportable incidents reported for the service from September 2017 to August 2018. Medical ionising radiation includes x-rays and nuclear scans, and treatments such as radiotherapy. It is widely used in hospitals, dentists, clinics and in medical research to help diagnose and treat conditions. Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) sets out the responsibilities of duty holders (the employer, referrer, IR(ME)R practitioner and operator) for radiation protection. For example: minimising unintended, excessive or incorrect medical exposures ensuring the benefits outweigh the risks of each exposure (justification) keeping doses in diagnostics “as low as reasonably practicable” for their intended use (optimisation) Notifiable incidents under IR(ME)R are those where a dose “much greater than intended” has been delivered to an individual and should be reported to the appropriate authority. Under-doses are not notifiable but must still be locally investigated.
- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses. Staff reported incidents using an electronic reporting system. The service had an incident reporting policy and procedure in place to guide staff in the process of reporting incidents. The service had recorded 147 incidents from August 2017 to August 2018. 48 incidents were graded as low, 84 incidents were graded as moderate. 15 incidents were graded as high.
- All incidents and complaints reported through the organisations electronic risk management system were reviewed on a weekly basis within the ‘complaints, litigation, incidents and compliments (CLIC)’ group by a multi professional team of governance and operational managers. Incidents involving patient or service user harm were assessed against the ‘notifiable safety incident’ criteria as defined within regulation 20 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. Incidents that met this threshold were managed under the organisations ‘adverse events (incident) reporting and management policy’ and ‘Duty of Candour, procedure for the notification of a notifiable safety incident’ standard operating procedure. Decisions relating to organisational disclosures made both under the statutory duty of candour framework and in the wider spirit of openness and transparency were recorded within the corresponding incident or complaint record and held within the electronic risk management system
- No duty of candour notifications were made between August 2017 and August 2018.
- From reviewing the incident log, we could see staff reported incidents as per policy for example, staff had reported errors in the booking process, any concerns about confidentiality and unexpected findings. We saw evidence the service looked-for opportunities to learn lessons from these incidents. There were thorough and robust investigations, all relevant staff had been involved in the review or investigation.

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- Staff used The Society of Radiographers (SoR) “Paused and Checked” system. Referrer error was identified as one of the main causes of incidents in diagnostic radiology, attributed to 24.2% of the incidents reported to the CQC in 2014. The six-point check had been recommended to help combat these errors. Pause and Check consisted of the three-point demographic checks to correctly identify the patient, as well as checking with the patient the site/side to be imaged, the existence of previous imaging and for the operator to ensure that the correct imaging modality is used.
- Relevant national patient safety alerts would be communicated by email to all staff. All staff had to accept emails with mandatory information in them this evidenced that they had been read.
- There were local procedures in place, which were being followed to ensure where there had been critical, urgent and unexpected significant radiological findings, the radiologist produced reports as quickly and efficiently as possible, the requesting doctor and/or their clinical team to read, and act upon the report findings as quickly and efficiently as possible.

Safety Thermometer (or equivalent)

- The service did not complete the safety thermometer as this was not applicable to the service they provided their patients.
- The service maintained on a unit level performance dashboard. This was updated daily and reviewed monthly by the manager and superintendent radiographer. The dashboard indicated the number of patients scanned, number of parts scanned, number of patients that did not attend, cancellations and feedback forms completed.
- The service recorded and reviewed daily safety checks, for example: emergency buzzer, intercom, cold head chirping, arrest trolley, temperature and air conditioning and unit emails.
- The performance dashboard and daily check were reviewed at least weekly and an action plan was used to monitor any omissions or concerns.

Are diagnostic imaging and endoscopy services effective?

(for example, treatment is effective)

We do not rate effective.

Evidence-based care and treatment

- Patients had their needs assessed and their care and treatment was planned and delivered in line with evidence-based guidance, standards and best practice.
- Relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment were delivered for example, National Institute for Health and Care Excellence (NICE) CG68 ‘Stroke and transient ischaemic attack in over 16s: diagnosis and initial management,’ NICE CG75 ‘Metastatic spinal cord compression in adults, Evidence-based indications for the use of PET-CT in the United Kingdom’ (2016).
- We saw no evidence of any discrimination, including on grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation when making care and treatment decisions
- Policies procedures and staff competence ensured, in relation to diagnostic procedures involving nuclear medicines, the practitioner noted the diagnostic reference level for each adult investigation. Activity for each exposure was the optimised so it is the lowest practicable dose to the patient.
- The service performed a monthly audit of all work undertaken by on site Radiologists. This was 10% of the total number reported. For outsourced reporting 10% of all work undertaken is also audited monthly

Nutrition and hydration

- There were no nutrition services for patients that attended for patients. However, staff had access to and could provide patients with a selection of refreshments (tea, coffee and water).

Pain relief

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- Patients were asked by staff if they were comfortable during their appointment, however no formal pain level monitoring was undertaken as these procedures were pain free.

Patient outcomes

- Information about the outcomes of people's care and treatment was routinely collected and monitored. The service recorded the time between when a referral to the service for a scan was received and that scan being booked. They also reported on the time between the scan to when the scan was reported on.
- Staff audited and compared key elements of the referral and scanning pathway and these were benchmarked with other InHealth locations.
- Audits of the quality of the images were undertaken at a corporate level and by the imaging provider. Any issues were fed back to local services for learning and improvement.
- The service performed a monthly audit of 10% of the total number reported work undertaken by the onsite radiologists. An audit was also carried out on the outsourced reporting, 10% of all work undertaken was also audited monthly. As this was a recently commenced audit, we were unable to review the most current information.
- The service had an audit schedule. The audits aimed to assist in monitoring the service and drive improvement. It involved all staff ensuring they had ownership of things that had gone well and that needed to be improved. Audits included hand hygiene, health and safety and patient experience.
- The service submitted a quarterly quality schedule and commissioning for quality and innovation (CQUIN) report to the clinical commissioning group (CCG). The purpose of this was to provide data required for CCGs to assess and pay providers based on their performance. The service reported on:

Domain 1: Preventing people dying prematurely:

- The service provided information to ensure people received healthcare from healthcare workers who effectively decontaminated their hands immediately before and after every episode of direct contact or care. The service submitted their hand hygiene audits.

- The service provided information on how they ensured promoting an ethic of learning, it was essential that early warning signs of possible quality and safety problems were investigated and acted upon. The service submitted a quarterly incident report detailing: Trends, learning and changes to practice as a result of learning.

Domain 3: Helping people to recover from episodes of ill health or following injury.

- The service provided information on how patient's experienced safe and co-ordinated care with clear and accurate information exchange with patients GP following an episode of care. The service submitted twice yearly audit (quarter two and quarter four) of 30 sets of notes.

Domain 4: Ensuring that people have a positive experience of care

- The service provided information on how they evidence patient experience data collection methodologies that show changes to patient experience across the organisation. The service submitted a quarterly patient experience report to that included examples of themed feedback and improvements made/lessons learnt from a variety of sources.
- The service provided evidence to show there were compliant with the standards for complaints management set out in the CQC's Key Lines of Enquiry (which are based on 'My Expectations' Parliamentary and Health Service Ombudsman, 2015.) The service provided: In quarter one, an internal audit of all staff with direct patient contact to establish if any further information / training is required. In quarter two, a copy of the complete pathway for 5 complaints which included all of the indicators and also how learning had influenced/changed practice both within the identified MK service and across other MK services.

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

- The service provided evidence to show all staff were compliant with safeguarding children and adult training commensurate with their role and

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responsibilities levels aligned to Safeguarding Children and Young People and Adult Intercollegiate Document. The service provided a quarterly report identifying the % of staff trained at appropriate levels.

- The service provided evidence to show they were compliant with the NHS Milton Keynes Clinical Commissioning Group (MKCCG) Serious Incident Policy The service provided submission of any RCA's will be monitored by MKCCG for compliance.
- The service provided evidence quality of care was improved by ensuring the workforce were supported through a regular system of appraisal and education that promotes their professional development and reflects any relevant regulatory and/or professional requirements. The service provided an end of year report which demonstrated 90% of relevant staff were up to date with their appraisal.
- The service provided evidence the service had sufficient staffing capacity and capability to provide high quality care to patients. The service provided a report on staffing to their provider Board (copied to the CCG) on a quarterly basis including identifying effects on quality and impact on patient care, when fill rates are below 95% threshold.
- The service provided evidence the service had in place a systematic approach to learning from a range of reports such as (but not limited to) The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports, National Enquiry Reports, Independent reviews of care and treatment, NICE guidance reviews. The service carried out an internal gap analysis which outlined reports reviewed and actions taken/planned with completion dates. All requests for gap analysis were being discussed and agreed at contractual meetings. The CCG could randomly request the providers assessment against specific NICE guidelines and actions being taken to meet any gap.
- Evidence submitted to the CCG demonstrated the service were compliant in all areas reviewed in the quarterly quality schedule and commissioning for quality and innovation (CQUIN) report.
- Staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, took on new responsibilities and on a continual basis. Staff had regular meetings with their manager and a performance appraisal biannually to set goals to review them. At the time of inspection, all eligible staff (15) had received an appraisal in the last 12 months. All eligible (nine) staff had had their professional registration in the last 12 months. All eligible (nine) staff had had revalidated their professional registration in the last 12 months.
- Assurance of staff competence to perform their role within InHealth was assessed as part of the recruitment process, at induction, through probation, and then ongoing as part of staff performance management and the InHealth appraisal and personal development processes.
- All radiographers were HCPC registered and met the standards to ensure delivery of safe and effective services to patients.
- Key attributes to ensure staff suitability were assessed as part of the interview process which were based on predetermined questioning that aligned with the service's core values.
- Site orientation for all staff ensured their competency to perform their required role within their specified local area. For clinical staff, this was supported by a comprehensive competency assessment toolkit which covered key areas applicable across all roles, and then clinical competency skills relevant to their job role and experience. For staff joining with experience, this was completed within the probation period. Those who were newly qualified or undertaking training a new modality, this was completed as the competency was acquired.
- InHealth had developed a comprehensive internal training programme for MRI aimed at developing MRI specific competence following qualification as a radiographer.
- In the event of any aspect of competency falling short of the required standard, the practitioners line manager was responsible for providing necessary support and guidance required to attain the relevant standard.

Competent staff

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- Ongoing staff competence was managed through the performance review process, for example where local audit, complaints and incidents, that highlighted potential failing areas where different staff members may need support and development.
- Clinical staff were required to complete continued professional development (CPD) to meet their professional body requirements.
- The service operated a comprehensive mandatory and statutory training programme which ensured relevant knowledge and competence was maintained and updated throughout the lifespan of employment with the organisation.
- Radiographers' scanning performance was monitored through peer review and issues were discussed in a supportive environment. Radiologists also fed back any perceived issues with scanning to enhance and learning or improvements in individual performance.
- Staff told us the service was committed to the continuing development of staff and offered access to both internal and externally part funded training programmes and apprenticeships to support staff in developing skills and competencies relevant to their career with InHealth.
- The service had robust arrangements in place for granting and reviewing practising privileges.

Multidisciplinary working

- All necessary staff, including those in different teams and services were involved in assessing, planning and delivering people's care and treatment. Staff based within the service worked closely with the referring NHS trust, this ensured a smooth pathway for patients.
- Staff working in the service had good relationships with external partners and undertook scans for local NHS providers and a private provider. We saw good communication between services and there were opportunities for staff to contact refers for advice and support.

Seven-day services

- The site operated seven days a week between the hours of 8am and 8pm.

- A senior manager was available in an on-call capacity out of usual office working hours
- No clinical emergency patients or persons under the age of 18 were scanned within the service.

Health promotion

- Information leaflets such as understanding your CT scan, understanding your MRI scan were sent to patients with their appointment letters and were available in the waiting rooms. These leaflets included information about what the scan would entail and what was expected of the patient before and after the scan appointment. Health promotion information leaflets and posters on subjects such as smoking cessation services and information on living with dementia, stroke and cancer were on display in the waiting rooms. The service also provided a range of information leaflets for patients and relatives, including dementia UK, deep vein thrombosis a physiotherapy services which patients could take away.

Consent and Mental Capacity Act

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. Staff had received training on mental capacity. They were aware of what to do if they had concerns about a patient and their ability to consent to the scan. They were familiar with processes such as best interest decisions.
- There were no patients attending the service at the time of inspection, who lacked capacity to make decisions in relation to consenting to treatment. Staff told us if, for example, a patient living with dementia was due to attend the service, they would be encouraged to attend with a relative or carer to provide the necessary support.
- Interventional procedures were consented for appropriately. A corporate consent policy written was available to staff, it was written in line with national guidance. We reviewed six patient care records all included a consent to treatment record. We observed staff obtaining verbal consent from the patients during

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their interventions. Scan safety consent forms were completed by all patients prior to their scan, to record the patients' consent. These also contained patient's answers to safety screening.

- The staff we spoke with were aware of the need for consent and gave patients the option of withdrawing their consent and stopping the scan at any time. Patients we spoke confirmed their consent had been obtained throughout the scanning process.

Are diagnostic imaging and endoscopy services caring?

Good 

We rated this service as **good**.

Compassionate care

- We observed all staff treating patients with dignity, kindness, compassion, courtesy and respect. Staff introduced themselves prior to the start of a patient's treatment, interacted well with patients and included patients during general conversation.
- Staff understood and respected patient's personal, cultural, social and religious needs, and they took these into account
- Staff took the time to interact with patients who use the service and those close to them in a respectful and considerate manner. They showed an encouraging, sensitive and supportive attitude to patients who use services and those close to them. Care observed met National Institute for Health and Care Excellence (NICE) QS15 Statement 1: 'Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty', NICE QS15 Statement 2: 'Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills', NICE QS15 Statement 3: 'Patients are introduced to all healthcare professionals involved in their care and are made aware of the roles and responsibilities of the members of the healthcare team' and NICE QS15 Statement 13: 'Patients' preferences for sharing information with their partner, family members and/or carers are established, respected and reviewed throughout their care'.

- We spoke with seven patients, all said they had been very happy with the service they had received. One patient described the service as fantastic, another as really well run. No patients raised any concerns about their treatment. Patients told us they were treated with respect, care, compassion and respect. Efforts had been made to maintain patients' dignity especially during scans of intimate areas.
- InHealth gave every patient the opportunity to complete the NHS Friends and Family Test (FFT) and indicate their likelihood to recommend the service. There was an opportunity to add free text comments on any positive or negative aspects. The FFT process used a paper-based form complete with QR code and URL so that patients may choose to complete it digitally on a personal device. The results were collated by an external provider and delivered to service managers through the InHealth intranet weekly and through a web-based dashboard accessible to all managers and staff. Service managers reviewed the results which summarised response rates (27.7% for this location) and overall likelihood to recommend (currently 99%+) and unlikely to recommend (currently 1%). The free text comments were interrogated to enable positive staff feedback and individuals could be praised where they noted for the quality of care delivered. Negative comments were scrutinised for opportunities to drive improvement in the service.

Emotional support

- Staff understood the impact that a patient's care, treatment or condition had on their wellbeing and on their relatives, both emotionally and socially. A patient described how when they had been given unexpected news, they had been spoken to sensitively.
- Staff were aware patients attending the service were often feeling nervous and anxious. Staff provided reassurance and support and demonstrated calm and reassuring approach.
- Staff signposted patients to other services appropriately if necessary. They saw providing support to patients and those close to them as an important part of their job.

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- Staff told us, if a patient became distressed rather than provide support to them in an open environment, staff could take them in to a private room to talk to them to assist them to maintain their privacy and dignity.

Understanding and involvement of patients and those close to them

- We observed staff communicating with patients so that they understood their care, treatment and condition.
- Staff recognised when patients and those close to them need additional support to help them understand and be involved in their care and treatment and enable them to access this. This included, for example, access to language interpreters, sign language interpreters, specialist advice or advocates.
- Staff made sure that patients and those close to them, were able to find further information or ask questions about their care and treatment. The service ensured a wide range of leaflets were available, for example, information about the particular scan the patient was having and also information about common health conditions.
- The service allowed for a parent or family member or carer to remain with the patient for their scan if this was necessary.

Are diagnostic imaging and endoscopy services responsive to people's needs? (for example, to feedback?)

Good 

We rated this service as **good**

Service delivery to meet the needs of local people

- Information about the needs of the local population was used to inform how services were planned and delivered. The service provided extra MRI, CT, DEXA and ultrasound scanning for the local NHS trust, the local clinical commissioning group (CCG) and also for a local private provider. The unit provided services through contractual agreements.

- Progress in delivering services against the contractual agreement was monitored by the NHS trust, CCG and private provider through key performance indicators, regular contract review meetings, and measurement of quality outcomes including patient experience. Performance was reviewed and service improvements agreed at these quarterly meetings.
- The extended opening hours of seven days per week 8am until 8pm, gave patients a greater choice of appointment times and as a result had assisted in reduced waiting time for examinations.
- The service provided services for a range of patients, however it was recommended patients whose mobility required a hoist, were referred to another InHealth service at the nearby hospital site.
- The service was accessible through established bus and train routes. There was a bus stop and a train station within a short walk. Patients were also able to use accessible car parking. Parking costs were applicable but up to three hours free parking was available with a two-minute walk.
- The facilities and premises were appropriate for the services that were planned and delivered. There was sufficient comfortable seating, toilets changing rooms and a drinks machine.
- Information was provided to patients in accessible formats before appointments. Appointment letters containing information required by the patient such as contact details, a map and directions, health professional's name if appropriate, and information about any tests or intervention including any if samples or preparation such as fasting was required. The appointments letters were sent out, asked patients to call in if they had any queries or if they had answered yes to any of the questions on the MRI safety questionnaire.
- All appointments were confirmed two days prior to patient's appointment, by phone. This helped reduce the number of do not attend (DNA's) and also provided an opportunity for the patient to ask us any questions they may have. Should a patient not be verbally contacted prior to their appointment, for

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example where a message is left for the patient on an answer machine, the patient was asked to call the service to confirm their intention to attend the appointment.

Meeting people's individual needs

- Services were planned to take account of the needs of different people, for example, on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation. Staff had received training in equality and diversity and had a good understanding of cultural, social and religious needs of the patient and demonstrated these values in their work.
- Reasonable adjustments were made so disabled patients could access and use services on an equal basis to others. All patients were encouraged in the appointment letter, to contact the unit if they had any particular needs, concerns or questions about their examination.
- The service provided imaging for outpatients, The CT, MRI and ultrasound scanners were in room on ground level so they were accessible for all patients. There was a lift to enable access to the DEXA scanner on the first floor. There was an accessible disabled toilet.
- A MRI compatible wheelchair and trolley were available should the patient be unable to mobilise independently from the waiting area to the MRI room. It was recommended where patients required access to a hoist, they were referred to the InHealth service based at the local acute trust.
- Interpreters could be provided if the service was informed prior to the appointment. Staff also had access to a telephone translation service, where appropriate. In a clinical emergency, InHealth policy enabled staff to use a family member to translate at the radiographers' discretion.
- The service engaged with patients who were vulnerable and took actions to remove barriers when they found it hard to access or use services. For example, patients who had informed the service that they were nervous, anxious or phobic could be invited

to have a look around the unit prior to their appointments, so they could familiarise themselves with the room and the scanner to try to manage their anxieties.

- Staff provided patients with information leaflets and written information to explain their condition.
- During the MRI scan, staff made patients comfortable with padding aids, ear plugs and ear defenders to reduce noise. Patients were given an emergency call buzzer to allow them to communicate with staff should they wish. Microphones were built into the scanner to enable two-way conversation between the radiologist and the patient. Patients could bring in their own music for relaxation. A relative or carer could be present in the scan room if necessary and after they have been screened for safety.

Access and flow

- Patients had timely access to scanning. The service was open seven days a week between the hours of 8am and 8pm.
- Referrals were prioritised by clinical urgency and based on the agreed commissioning pathway. NHS patients received an appointment within four weeks, they did not offer an urgent pathway for NHS patients. All private patients were given an appointment within 48 hours.
- The service held some slots which were filled a day prior to allow for any clinically urgent referrals, if these were not filled by urgent cases, the service utilised these appointments for patients who could be contacted at short notice.
- Should the need arise to add an urgent referral into the waiting list when no appointments were available, the unit would assess appointments filled by routine, not urgent examinations and rebook patients to make room for the clinical urgent case. The rebooked patient would be given the next available appointment to suit the patient.
- Between August 2017 to August 2018, 34 planned procedures/examinations were cancelled for a non-clinical reason. Ten cancellations were due to machine breakdown or other equipment failure, other than equipment failure, weather, for example snow

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preventing staff/patients getting to the site, was the most common reason for cancellations. The weather had been particularly bad during the winter in the time period reported.

- Appointments generally ran to time; reception staff would advise patients of any delays as they signed in. Staff would keep patients informed of any ongoing delays through a notice board in the waiting area.

Learning from complaints and concerns

- Patients we spoke with knew how to make a complaint or raise concerns. The complaints procedure for the service was displayed in reception, the waiting areas, and in all clinical rooms for patients and those close to them to read. Staff told us they were happy to explain the procedure to patient ensuring they had any contact information required to issue the formal complaint. Advice on how to complain was also available on the provider's website.
- InHealth had a complaints' handling policy and all staff completed a mandatory training course on complaints management. The service operated a robust complaints management procedure which aimed to identify and address concerns in a mutually satisfactory manner. Patients and those close to them were encouraged to raise any concerns or issues with staff on duty or the person in charge in the first instance. Staff were empowered to attempt to resolve concerns locally wherever possible.
- Where a patient and those close to them chose to raise a 'formal' complaint, information leaflets explaining the process and available escalation pathways were available in each location where services were provided. Formal complaints were logged and recorded using the organisations electronic risk management system. InHealth aimed to acknowledge all complaints within three working days and investigate and formally respond within 20 working days. InHealth operated a three stage complaints management policy: Stage one - local resolution - investigation and response coordinated by local service/ CQC registered manager, Stage two: Internal director review, Stage three: External independent review. External review was provided by

either the Public Health Service Ombudsman for NHS funded patients or The Independent Healthcare Sector Complaints Adjudication Service (ISCAS) for privately funded patients.

- The service received ten complaints and 1,700 compliments between August 2017 and August 2018. All ten complaints were dealt with under the formal complaints procedure in accordance with the service's timescales. All ten were upheld. Complaint themes included: patient pathway (4), reports/results (2), staff related (2), clinical treatment (1) and communication (1).

Are diagnostic imaging and endoscopy services well-led?

Good 

We rated this service as **good**.

Leadership

- Leaders had the skills, knowledge, experience and integrity needed both, when they were appointed and on an ongoing basis.
- The InHealth management structure within the unit consisted an on-site 0.3 FTE Imaging services manager (ISM) and one full time equivalent (FTE) superintendent radiographer who was on site daily to assist with clinical issues, work and scan. The ISM also managed two other services, a MRI service based at the local acute trust and a number of mobile services. They were supported by a regional head of imaging services.
- The ISM was an experienced and competent senior radiographer. They were knowledgeable in leading the service. They understood the challenges to quality and sustainability the service faced and had pro-active ongoing action plans in place to address them.
- The ISM was enthusiastic and was keen to improve the quality and service provided. They told us they felt well supported by the corporate InHealth team to take forward initiatives and adjust the service if warranted.

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- The manager was visible and approachable and was clearly proud of the team. Staff said they felt confident to discuss any concerns they had with them.
- Staff we spoke with found the manager and the superintendent to be approachable, supportive, and effective in their roles. They all spoke positively about the management of the service.
- The service supported staff to develop within their roles. Staff said the ISM was committed to the continuing development of staff and offered access to both internal and externally part funded training programmes and apprenticeships to support staff in developing skills and competencies relevant to their career with InHealth.

Vision and strategy

- The service had a clear vision and a set of values, with quality and safety the top priority. InHealth had four clear values: Care, Trust, Passion and Fresh thinking. These values were central to all the examinations and procedures carried out daily. Following the company mission to 'Make Healthcare Better' enables all employees to offer a fresh, innovative approach to the care we deliver.
- Staff were aware and understood what the vision and values were and understood the strategy and their role in achieving it. All staff were introduced to these core values at the cooperate induction and then through their annual appraisal and all personal SMART objectives issued at each appraisal were linked to the company's objectives. An objective is a statement which describes what an individual, team or organisation is hoping to achieve. Objectives are 'SMART' if they are specific, measurable, achievable, realistic and, timely (or time-bound). Staff provided examples how they demonstrated the organisational values, with new ideas or examples of care. For example, the service had introduced a standard operating procedure (SOP) for extravasation following a complaint from a patient. Extravasation is the unintentional leakage of intravenous drugs into the surrounding perivascular tissue or subcutaneous spaces.
- We did not see evidence of a capital replacement plan at local level for the MRI scanner, the CT scanner, the DEXA Scanner and the Ultrasound machine. All the

diagnostic equipment on site was between eight and twelve years old and heading towards being at the end of their working lives. While the service had service level agreement to ensure all pieces of equipment were regularly checked and serviced, the service was not aware of the plan to replace the equipment. Potentially all scanning equipment could require replacement at the same time. This could impact on the service's ability to continue with the current service provision. This issue was not on the local risk register. Following the inspection, InHealth provided evidence that the service had a comprehensive plan to replace the equipment however, these plans were not managed by the registered manager at local level, medical equipment procurement was managed centrally under the capital equipment replacement programme.

Culture

- Staff felt respected and valued. Staff told us they felt supported, respected and valued by the organisation. Staff told us they felt proud to work for the organisation. All staff we spoke with were very happy in their role and stated the service was a good place to work. All staff talked about the very supportive staff team.
- The service's culture was centred on the needs and experience of patients. This attitude was reflected in staff we spoke with on inspection.
- Action was taken to address behaviour and performance that was inconsistent with the vision and values, regardless of seniority. Feedback from patients about the service they had received was acted on. In the event of any aspect of behaviour and performance falling short of the required standard, the practitioners line manager was responsible for providing necessary support and guidance required to attain the relevant standard.
- Staff said they felt well supported in their roles and would be able to challenge practice or raise concerns regardless of role or seniority if necessary. There were clearly defined management structures, however, staff told us they felt able to approach leaders across professional boundaries. For example, radiologists felt comfortable to raise concerns with the Imaging services manager (ISM).

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- The service promoted equality and diversity, it was part of mandatory training, inclusive, non-discriminatory practices were promoted.
 - A whistle blowing policy, duty of candour policy and appointment of freedom to speak up guardians supported staff to be open and honest.
 - Staff described the principles of duty of candour to us. Staff told us they attended duty of candour training.
 - All independent healthcare organisations with NHS contracts worth £200,000 or more are contractually obliged to take part in the Workforce Race Equality Standard (WRES). Providers must collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality. The provider had produced a WRES report in September 2017 including data from June 2016 - June 2017. There was clear ownership of the WRES report within the provider management and governance arrangements, this included the WRES action plan reported to and considered by the Board.
 - There was a system in place to ensure non-NHS-funded people using the service were provided with a statement that included terms and conditions of the services being provided to the person and the amount and method of payment of fees.
 - Staff ethnicity was not previously captured in the InHealth in the staff survey and self-reporting of ethnicity was low. There was no comparative data for 2016 as a result of this. The InHealth stated that this would be included within the 2018 report (not yet published).
- Governance**
- There was an effective governance framework to support the delivery of the strategy and good quality care. The service undertook a number of quality audits, information from these assisted in driving improvement and giving all staff ownership of things had gone well and action plans identified how to address things needed to be improved.
 - InHealth operated a comprehensive clinical governance framework which aimed to assure the quality of services provided. Quality monitoring was the responsibility of the location registered manager and is supported through the InHealth clinical quality team through the framework and governance committee structure. This included a quarterly risk and governance committee, clinical quality sub-committee, medicines management group, water safety group, radiation protection group, radiology reporting group and a weekly meeting for review of incidents and identification of shared learning.
 - Local governance processes were achieved through monthly team meetings and local analysis of performance, discussion of local incidents. Feedback and actions were fed into processes at a corporate level. We saw evidence of this process in meeting minutes and meeting notes during our inspection.
 - Staff were trained and supported to ensure they were competent in incident reporting, complaint handling. Staff were supported in developing local policies and protocols as well as implementing corporate policies and procedures.
 - Staff were clear about their roles and understood what they were accountable for. All clinical staff were professionally accountable for the service and care that was delivered within the unit.
 - Staff working with radiation were provided with appropriate training in the regulations, radiation risks, and use of radiation. However, it was not clear if staff were aware of the changes made by the introduction of the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER17) which had been introduced in February 2018. Following the inspection, the provider told us a presentation was planned for the team meeting on 18 October where the radiation protection supervisor (RPS) would discuss the new regulations and their impact on the current service.
 - There were processes in place to ensure staff were fit for practice, for example, they were competent and held appropriate indemnity insurance in accordance with The Health Care and Associated Professions (Indemnity Arrangements) Order 2014.
 - Working arrangements with partners and third-party providers were managed. There were service level agreements between the service and the local acute

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trust, the clinical commission group and a private provider. The service provided quarterly quality reports and regular meetings to discuss the service provided.

Managing risks, issues and performance

- There was a risk assessment system in place locally with a process of escalation onto the corporate risk register. The local risk register was reviewed and updated and some new risks added regularly. The risk register included quality performance, operations, human resources, health and safety, finance, legal, IT systems, procurement and information governance. An action log was also included identifying timescales and accountability. However, we were aware all the diagnostic equipment on site was between eight and twelve years old and heading towards being at the end of their working lives. While the service had service level agreement to ensure all pieces of equipment were regularly checked and serviced, the service did not have a plan to replace the equipment. This was not on the local risk register.
- Performance was monitored on a local and corporate level. Performance dashboards and reports were produced which enabled comparisons and benchmarking against other services. Information on turnaround times, 'did not attend rates', patient engagement scores, incidents, complaints, mandatory training levels amongst others were charted.

Managing information

- Electronic patient records were kept secure to prevent unauthorised access to data however authorised staff demonstrated they could be easily accessed when required.
- Staff had access to InHealth policies and resource material through the InHealth computer system.
- There were sufficient computers available to enable staff to access the system when they needed to and the manager had a laptop computer.
- Staff were able to locate and access relevant and key records easily, this enabled them to carry out their day to day roles

- Information from scans could be reviewed remotely by authorised referrers to give timely advice and interpretation of results to determine appropriate patient care.

Engagement

- Patients' views and experiences were gathered and acted on to shape and improve the services and culture. Patient surveys were in use, the questions were sufficiently open ended to allow people to express themselves. We saw changes were implemented following feedback from patients. Following a complaint about the conduct of a staff member, following investigation the staff member had been set some personal objectives to improve the way they interact with patients.
- Staff told us they felt actively engaged, their views were reflected in the planning and delivery of services and in shaping the culture. Annual staff satisfaction surveys were undertaken. These were used to seek views of all employees within the organisation and actions implemented from the feedback received. The Midlands results for January 2018 survey which indicated 85% of staff said, at work, "I have the opportunity to do my best every day", 90% of staff said, "if one of my friends or family needed care or treatment, I would recommend InHealth's services to them", 93% of staff said, "patient safety is a key priority at InHealth" and 89% said, "equality and diversity are valued at InHealth".
- The service engaged regularly with commissioners to understand the service they required and how services could be improved. This produced an effective pathway for patients. The service had a good relationship with local NHS trust.
- An employee wellbeing and assistance programme was available to staff to support them during times of crisis and ill-health.

Learning, continuous improvement and innovation

- Staff could provide examples of improvements and changes made to processes based on patient feedback, incidents and staff suggestion. Staff were alert to new initiatives and ways of working. For example, the service had introduced a standard operating procedure (SOP) for extravasation following

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a complaint from a patient. Extravasation is the unintentional leakage of intravenous drugs into the surrounding perivascular tissue or subcutaneous spaces. The SOP provided better guidance for the clinical team to ensure that the patient was cared for appropriately and informed. It also ensured a consistent approach to extravasation. Any extravasation was documented and followed up to ensure the patient did not suffer any pain or further complications after they leave the site. All clinical staff we spoke with were aware of the incident and the improvements that had been put in place.

- The team were proactively improving care for patients using the service. The service had recently reviewed the management and support structure of the clinical teams and employed a second superintendent, this was to provide day to day line management and clinical support to the team.
- The team had improved the efficiency of the DEXA service by changing the report procedure from a manually dictated report to an electronic report, the

reporter could access images and referrals off site. This has meant the reports could be completed in a much quicker timeframe. The patient data was also more secure using this method.

- The service had revised the cardiac CT service. The had implemented a new standard operating procedure so the process was clearer and safer for the team to operate. most radiographers had been trained to immediate live support (ILS) level to support this service in the community setting. The service had invested in new equipment to improve the safety of this service, a new defibrillator machine with pace option for the cardiologist to use if required and an electrocardiogram (ECG) machine to monitor patients better.
- The service was signed up to the NHS "SIGN UP TO SAFETY" CQUIN, working on a yearly action plan in the aim to improve quality and safety for patients.
- InHealth were working towards accreditation with the Imaging Services Accreditation Scheme (ISAS). The director of clinical quality is leading on the accreditation.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **SHOULD** take to improve

- The service should ensure all risk items are recorded on the local risk register.
- The service should ensure staff and patients are made aware of the changes required following the

introduction of the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER17) which had been introduced in February 2018.

- The service should provide sufficient storage in the CT room ensuring all equipment is stored off the floor.