InPhase Mobile MRI Services Ltd

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Inspection report

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Date of inspection visit: 07 December 2021
Date of publication: 22/02/2022

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Requires Improvement
Are services effective?	Inspected but not rated
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

We rated the service as inadequate because:

- The service did not provide mandatory training in key skills to all staff or have robust processes in place to make sure everyone completed it.
- Staff did not always receive the appropriate training on how to safeguard patients in line with best practice.
- The provider did not have a recruitment process in place to ensure that both directors and employees satisfied the necessary requirements needed for their role.
- Staff did not always record detailed discussions of the consent process.
- Managers did not always assess the effectiveness of the service, staff compliance of adhering to policies was not audited and actions were not always taken from audits to improve outcomes for patients.
- Staff did not receive a full induction programme which prepared and supported them to undertake their role
- The service did not display complaint information making it difficult for patients to share negative feedback.
- The service did not maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided and discussions of consent.

However:

- The service had enough staff to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff assessed risks to patients and acted on them.
- The service was inclusive and took account of patients' individual needs and preferences, reasonable adjustments were made to help patients access services.
- Patients could access the service when they needed it and received the right care promptly.

Following our onsite inspection, we spoke to and provided written feed back to the service regarding our concerns with the recruitment and governance processes. We requested that they send further assurances, however, following a review we continued to have concerns. As such we served the service with a Warning Notice under Section 29 of the Health and Social Care Act 2008. The warning notice told the service that they needed to make significant improvements in their governance processes to ensure the quality and safety of services provided. The principles we use when rating providers requires CQC to reflect enforcement action in our ratings. This means that the warning notice we served has limited the services rating.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Inadequate 	We rated the service as inadequate because: • The service did not provide mandatory training in key skills to all staff or have robust processes in place to make sure everyone completed it. • Staff did not always receive the appropriate training on how to safeguard patients in line with best practice. • The provider did not have a recruitment process in place to ensure that both directors and employees satisfied the necessary requirements needed for their role. • Staff did not always record detailed discussions of the consent process. • Managers did not always assess the effectiveness of the service, staff compliance of adhering to policies was not audited and actions were not always taken from audits to improve outcomes for patients. • Staff did not receive a full induction programme which prepared and supported them to undertake their role • The service did not display complaint information making it difficult for patients to share negative feedback. • The service did not maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided and discussions of consent. However: • The service had enough staff to keep patients safe from avoidable harm and to provide the right care and treatment. • Staff assessed risks to patients and acted on them. • The service was inclusive and took account of patients' individual needs and preferences, reasonable adjustments were made to help patients access services. • Patients could access the service when they needed it and received the right care promptly.

Summary of findings

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Summary of this inspection

Background to InPhase Mobile MRI Services Ltd

InPhase Mobile MRI Services Ltd provides diagnostic and/or screening services using diagnostic imaging in the form of Magnetic resonance imaging (MRI).

InPhase Mobile MRI Services Ltd was registered in 2018 based in Yorkshire aiming to deliver mobile and relocatable MRI scanning services commissioned by the NHS and Private Health Care Sector on a supply and demand basis. Due to the COVID-19 pandemic, InPhase Mobile MRI Services Ltd had not acquired a mobile MRI scanner, and was primarily delivering diagnostic screening by InPhase staff within NHS trusts using the trust's MRI equipment.

We conducted an announced, comprehensive inspection on 7 December 2021. This service had not previously been inspected and therefore did not have a rating. The location is registered to provide the regulated activity: Diagnostic and screening procedures. The location has two managers registered with the CQC.

How we carried out this inspection

We inspected the location using our comprehensive methodology as the service had not previously been inspected.

Our inspection was announced (staff knew we were coming) 24 hours before the inspection to enable us to direct our inspection resources.

The team that inspected the service comprised of one CQC inspector and a specialist advisor. The inspection team was overseen by Sarah Dronsfield Head of Hospital Inspection.

Due to the COVID-19 pandemic on 13 December 2021 the Care Quality Commission postponed its on-site regulatory activity including direct monitoring activity in acute hospitals, ambulance services and general practice, with immediate effect due to the acceleration of the vaccine booster programme. Therefore, we were unable to speak with staff or patients or visit the MRI environment as this was located on an acute NHS site. We inspected key lines of enquiry in the safe, effective, responsive and well-led key questions.

During the inspection visit, the inspection team:

Spoke with the two registered managers of the service. The registered managers also owned and were appointed directors of the company.

Looked at a range of policies, procedures and other documents relating to the running of the service

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

Summary of this inspection

Areas for improvement

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

Action the service MUST take to improve:

- The service must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints. Information must be available to the complainant about how to take action if they are not satisfied with how the provider manages or responds to their complaint (Regulation 16)
- The service must ensure that there is a system and process used to confirm that individuals, appointed as a director of the service provider or someone performing those functions, satisfies the necessary requirements, and is monitored for completeness (Regulation 5 (2))
- The service must ensure that there is a system and process used to confirm that individuals, employed for the purposes of carrying on a regulated activity, satisfies the necessary requirements, and is monitored for completeness. (Regulation 19(2))
- The service must have systems and processes such as regular audits of the service provided and must assess, monitor and improve the quality and safety of the service. (Regulation 17 (2)(a))
- The service must maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user. This must include decisions taken in relation to the care and treatment provided and consent including when consent changes and why the person changed consent (Regulation 17 (2)(c)).

Action the service SHOULD take to improve:

- The service should ensure that governance processes capture how the latest national guidance and evidence-based practice is cascaded.
- The service should ensure a system is implemented to record and monitor incidents, investigate them appropriately and identify themes and trends.
- The service should ensure that all staff receive safeguarding training for adults and children to the correct level, as necessary, to evidence that systems and processes are operated effectively to prevent abuse of service users.
- The service should ensure that all staff receive an induction programme and are supported to undertake training, learning and development that prepares and enables staff to fulfil the requirements of their role and review this at appropriate intervals.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic and screening services	Requires Improvement	Inspected but not rated	Not inspected	Requires Improvement	Inadequate	Inadequate
Overall	Requires Improvement	Inspected but not rated	Not inspected	Requires Improvement	Inadequate	Inadequate

Inadequate

Diagnostic and screening services

Safe	Requires Improvement
Effective	Inspected but not rated
Responsive	Requires Improvement
Well-led	Inadequate

Are Diagnostic and screening services safe?

Requires Improvement

Mandatory training

The service did not provide mandatory training in key skills to all staff and made sure everyone completed it.

The service did not monitor mandatory training or alert staff when they needed to update their training. Staff were expected to keep as close to 100% completion of mandatory training from their employment within an NHS trust. Managers requested mandatory training figures from staff on an irregular basis and did not ensure that staff remained up to date with necessary training for their role. However, although managers did not have an effective process to monitor this, staff were up to date with training in the examples we saw.

The mandatory training was not always comprehensive and did not always meet the needs of patients and staff. We requested the mandatory training for an administrative employee that did not hold substantive employment with the NHS. We found that their training did not include all mandatory modules such as information governance. This training did, however, include safeguarding children, infection prevention and control (IPC), health and safety, basic life support and moving and handling.

Safeguarding

Staff did not always have training on how to recognise and report abuse. Staff were given information on how to appropriately raise a safeguarding referral.

The provider had not ensured that recruitment procedures to employ staff kept people safe from harm. For example, the provider relied upon staff having substantive employment within an NHS trust and their recruitment procedures being robust; but had not seen evidence themselves of the appropriateness of employees. For the one member of staff that did not hold alternative employment, the provider had requested a Disclosure and Barring service check (DBS), however this was not enhanced and did not cover both adults and children in line with provider policy. A DBS check is an official record stating a person's criminal convictions.

Following the inspection, the provider took immediate action in response to feedback to ensure staff recruitment checks met the necessary requirements. Evidence was provided that staff had declared they had a valid DBS check, character references, employment history and qualifications. For the staff member without an appropriate DBS, their employment was suspended temporarily, and the correct DBS check had been applied for.

Inadequate

Diagnostic and screening services

The service did not have a robust process to monitor safeguarding training or alert staff when they needed to update their training. The provider depended on staff completing safeguarding training within their substantive employment within the NHS and did not have a robust process to monitor their completion, however staff were up to date with safeguarding training from their substantive employment with NHS in all staff files we looked at.

The safeguarding training certificates of one staff that did not hold employment with the NHS were requested, one certificate for children's safeguarding was provider that did not specify a training level. However, following the inspection, the provider sent two certificates which demonstrated the member of staff had both children's and adults safeguarding training to an appropriate level in line with intercollegiate guidance (2019).

The service had an up to date safeguarding policy for protecting vulnerable adults and children.

Staff were given information on how to make a safeguarding referral and who to inform if they had concerns. The provider identified the safeguarding process of each hospital they were working within and cascaded this process to staff.

Environment and equipment

The provider ensured that the design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

We were told staff showed patients how to use the call bell whilst in the MRI scanner.

Staff carried out daily safety and monthly checks of emergency resuscitation equipment. We saw examples of when the provider had replenished items missing from the trolley however, staff were not given a process of how to escalate any discrepancies found on the trolley.

The service ensured the environment had enough suitable equipment for staff to safely care for patients by assessing the site before carrying out the regulated activity.

Staff reported any equipment and scanner faults to the host trusts estates department. The service had an agreement in place with the host trust which showed that the trust was responsible for the inspection and maintenance of scanning equipment.

Assessing and responding to patient risk

Staff identified, responded to and removed or minimised risks to patients. Staff identified and quickly acted upon patients at risk of deterioration

There was a process in place to respond to emergency situations. Staff were made aware of the process of how to respond to deterioration in a patient's health. The service adopted the hospital's deterioration procedure and gained assurance staff had read and understood this.

All staff were trained to perform adult basic life support (BLS). They would act in accordance with their training until the hospital's resuscitation team arrived.

Staff were made aware of information about how to respond to specific risk issues such as sepsis. The service adopted the hospital's policy about recognition of relevant risks of deterioration and ensured that staff were given access to the information through the hospitals intranet.

Inadequate

Diagnostic and screening services

Staff completed an MRI safety questionnaire with a patient before any scan. This was signed by the patient and radiographer before the form was scanned onto the patient record system. We saw examples of where staff use of the MRI safety questionnaire had prevented patients from receiving an unsafe scan.

Risks were identified prior to administering contrast agents to patients. The provider had a policy in place for staff to follow when administering contrast agents. This included that contrast agents should not be administered if there was any question about renal (kidney) function, and that minimum doses should be given dependant on a patient's weight. Staff used the NHS paperwork to identify this information before administered contrast agents.

Staff shared key information to keep patients safe when handing over their care to others. The staff used the system of the hospital they were working within enabling them to hand over images and patient information immediately.

Staff always had access to the trust's on call radiologist for further advice on MR images.

Shift changes and handovers included all necessary key information to keep patients safe. The provider implemented an 'End of day' handover sheet which included any key information about each patient.

Staffing

The service had enough staff but were not always assured staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service worked flexibly to meet the demand of the trust which they had a contract with. Staff were employed using casual worker agreements. Staff availability was given to the hospital two to four weeks in advance allowing the hospital to schedule MRI lists.

Staffing levels were increased to meet the needs of patients. The service had increased the amount of days they provided staff to the hospital, from two to five days a week, due to demand and shift patterns were 12 hours long. This was to help reduce waiting times for patients. Each list left a small number of appointment times available so that they were able to accept urgent referrals.

Managers ensured there were enough radiographer and health care assistant staff to keep patients safe. Two staff were present at every scan.

The service had low vacancy and turnover rates.

The service had contingency plans in place in the event of staff sickness. Both managers were trained radiographers and therefore could cover for any unexpected staff sickness.

However, staff did not receive an induction that supported them to undertake training, learning and development to fulfil the requirements of their role.

Records

Staff were given access to records of patients' care and diagnostic procedures.

Staff had access to information on patients' care and procedures. All staff had access to the NHS trust's electronic records system that they could update.

Inadequate

Diagnostic and screening services

Staff were given access and their own log in credentials for the IT systems of the trust they were working in, this gave them easy access to policies and patient records.

Staff records were stored securely.

Medicines

The service did not use systems and processes to safely administer patient group directions.

Managers did not assess staff's ability to administer Patient Group Directions (PGD) in line with best practice guidance. A PGD is a written direction that allows the supply and administration of specified medicines, by a named authorised health professional, to a defined group of patients.

However, staff received medicine safety training in their substantive employment with an NHS trust and we saw staff were up to date with this. Staff read and understood the PGD's. Staff were given authorisation to supply and administer medication under PGD once they had received this.

Incidents

The service did not manage patient safety incidents well. Managers did not investigate incidents and share lessons learned with the whole team and the wider service.

Managers did not investigate incidents thoroughly. The provider directed staff to escalate incidents using the reporting system of the host trust, the service level agreement detailed that the trust would inform the provider of any such incidents. However, managers did not formally or regularly audit patient notes or handover documents to ensure that staff were correctly escalating patient safety incident.

Are Diagnostic and screening services effective?

Inspected but not rated

Evidence-based care and treatment

The service did not always provide care and procedures based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance.

Managers did not audit staff compliance with policies. For example, the consent policy required staff to record the discussion around consent, however there was no consent audit to identify whether this was taking place. The documentation for Gadolinium-based contrast agent (GBCA), drugs given by injection used in diagnostic imaging procedures to enhance the quality of magnetic resonance imaging, did not have anywhere for staff to document consent discussions and there was no audit to identify this.

The service did not hold speciality meetings to review and implement the latest guidance. We reviewed governance meeting minutes and saw that changes to guidance were not discussed.

Inadequate

Diagnostic and screening services

The service did not have a formal process to ensure that staff kept up to date with imaging guidance. However, staff shared practice and learning from their substantive employment in the NHS for managers to implement in the service. The service applied imaging protocols created in accordance with NICE guidelines and the Royal Collage of Radiologists overseen by the host trusts on-site medical physics team. Staff had access to the trust's medical physics expert for advice when required.

Pain relief

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

Staff assessed patients for discomfort throughout their procedure. Staff had to discuss use of patient alerts and demonstrate patient comfort options and how to monitor them as part of their site induction.

Patients could stop the procedure at any time. Staff would pause a scan if a patient was uncomfortable and bring them out of the MRI machine, patients would then be giving the choice of trying again or stopping the procedure.

Pain relief would not be offered to patients using the service, but information given before the procedure directed patients to seek advice from their GP on being prescribed an anxiolytic medication (treatment for anxiety) prior to the scan if they felt uncomfortable.

Patient outcomes

Staff did not monitor the effectiveness of care. They did not use the findings to make improvements and achieve good outcomes for patients.

The service did not participate in relevant national clinical audits and therefore managers and staff could not use the results to improve patient outcomes.

Managers and staff did not carry out a comprehensive programme of repeated audits to check improvement over time. The provider did not carry out any clinical audits except for a monthly image quality audit. This meant that managers were unable to use information from audits to improve care and treatment for patients.

However, outcomes for patients were positive, consistent and met expectations. The service had not received any recall of images (due to poor quality) during their practice and had received positive feedback from the NHS hospitals they had worked within.

Managers shared and made sure staff understood information from the audits that took place (image quality and hand hygiene) and implemented actions when identified. For example, in the latest hand hygiene audit in November, there was 7% failed moments of hand washing. This was fed back to staff with an action to repeat the audit to identify improvement.

Competent staff

Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Inadequate

Diagnostic and screening services

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. However, during the COVID-19 pandemic face to face appraisals had been suspended, although telephone appraisals had been used as an alternative, there was only 43% compliance of staff participating in these.

Managers identified any specific training needs their staff had in relation to imaging and gave them the time and opportunity to develop their skills and knowledge. Managers used self-declaration to give staff the opportunity to identify any area's they would like to receive training in and made training recommendations within staff appraisal.

Staff had access to regular team updates and full notes of these were accessible. The service used an encrypted instant messaging application for the team to receive regular updates and this gave them opportunity to talk informally.

Managers gave all new staff an induction to their role before they started work.

Staff had to successfully complete a bespoke competency for each type of MRI scanner they would be using, this included being able to demonstrate use of the scanner, understanding how to safely scan a patient and being familiar with emergency procedures.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Managers attended collaboration meetings in their local NHS trust and regional Imaging Collaboration to keep up to date with information from the regional radiology network.

Staff were made aware of how to contact appropriate healthcare professionals, such as the medical physics expert and radiologists to escalate image findings within the trust they performed scans.

Health promotion

Staff did not always give patients practical support and advice to lead healthier lives.

Staff assessed each patient's health at every appointment prior and provided support for any individual needs or adjustments needed to receive their diagnostic scan.

The provider gave feedback, to the hospital patients were attending for an MRI, to improve the quality of information given prior to their scan. Managers told us current pre-advice information given to patients did not include details such as where on the body the scan would take place and they had escalated this with the trust.

However, the provider did not actively promote healthy lifestyles. For example, managers told us they regularly had to rebook patients to a different type of MRI scanner due to factors such as body mass index but did not offer any relevant information for health promotion.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health, however this was not always documented.

Inadequate

Diagnostic and screening services

The provider had a consent policy in place, due for review in April 2022, to support staff in understanding how and when to assess whether a patient had the capacity to make decisions about their care. Staff were given access to both the provider policy on Mental Capacity Act and Deprivation of Liberty Safeguards and that of the current trust they were working within.

Staff determined whether patients could give consent to a procedure by ensuring they could complete the MRI safety questionnaire or understand the scan process. When a patient could not give consent, staff referred them back to the main hospital department for necessary adjustments to be made.

Staff made sure patients consented to treatment based on all the information available.

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

However, staff did not clearly record consent in the patients' records in line with provider policy. The service used consent documentation from the hospital they were working within. For intravenous GBCA the documentation did not have a section for verbal, implied or written consent to be documented and therefore it was not always evident if patients had consented to the procedure.

Managers did not monitor how well the service followed the Mental Capacity Act and made changes to practice when necessary.

The service did not evidence the use of Gillick Competence (test used to decide whether a child can consent to treatment) to support children who wished to make decisions about their own care. Policies used to support decision making did not refer to Gillick Competence when seeing children and so staff lacked guidance on the test and how to use it. However, the policy did make reference to younger children who are able to fully understand a proposed procedure, could give consent ideally with the involvement of their parents.

Are Diagnostic and screening services responsive?

Requires Improvement

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The service had adapted its provision to the continually changing picture of the COVID-19 pandemic. The business was originally developed to offer mobile MRI services to add scanning capacity in West Yorkshire. However, during the COVID-19 pandemic, the provider supported the NHS by providing skilled radiographer staff to address waiting lists for MRI scans.

The service used the NHS framework to identify demand for radiographers in the local area and applied for these agreements to support the NHS.

The provider offered a mobile waiting area as an optional part of their service to increase patient comfort. Managers told us that many of the MRI scanners they used were located outside of the main departments of hospitals and therefore they had introduced the mobile waiting area to improve patient experience.

However, managers did not need to monitor and take action to minimise missed appointments or ensure that patients who did not attend appointments were contacted. They told us that the hospital managed all patient bookings and non-attendances and followed the hospital's policy in relation to patients that did not attend. This meant that managers could not follow up with patients who did not attend to ensure they received the appropriate treatment and reduce future non-attendances.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The service ensured that they could give patients information in accessible formats. Before accepting a contract with a hospital, the demographic of the population was considered, and managers ensured the hospital had appropriate information in different formats and languages and had access to interpreters when required.

Managers had developed a children's animation, in collaboration with an NHS trust, to support their understanding of the MRI process. Although children's books were also available, management told us that they wanted to deliver information in modern way and a format that children were very familiar with.

The service ensured that patients with anxieties or claustrophobia received support and comfort. The provider's claustrophobia policy informed staff of the ways they could minimise anxiety for patients including: a meet and greet stage, opportunity to talk through the procedure and any concerns, option for music to play, eye masks to be worn, to enter feet first where able, opportunity to pause or stop the scan or to signpost to the GP for anxiolytic medication. Managers audited scans that were terminated due to claustrophobic anxiety, only 1.2% of scans required cancellation for this reason.

Staff understood that because patients may have needed to undress and change into a gown this could increase feelings of vulnerable. A chaperone would be provided if requested by the patient to provide reassurance

Patients in need of additional intervention were supported. Staff ensured that incidental or unusual findings were escalated to the radiologist and escorted to the appropriate department if additional treatment was required on the same day.

Access and flow

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

The service provided flexible appointment times. Scans were offered flexibly, five days a week, including during evenings and on a Saturday.

Managers ensured there was sufficient time between scan appointments to resolve any unforeseen circumstances and reduce patient waiting times.

Inadequate

Diagnostic and screening services

The service provided a wide range of magnetic resonance imaging examinations in line with the contractual requirements of the trust which included but not limited to oncology, vascular, neurological, arthrography and cardiac.

Patient history was provided the week before their scan and reviewed by radiographer staff. This process helped to ensure cases were prioritised and the appropriateness of magnetic resonance imaging scan requests were controlled.

Urgent appointment slots were reserved on each scanning list. If not utilised, they were allocated to other referrals to ensure sessions were booked to maximise capacity and maintain short waiting times.

The service did had not have a mechanism in place to ensure that MRI scans were delivered to required timescales, such as Referral to Treatment (RTT) to ensure patients receive their diagnostic test within 6 weeks of referral, as this was the responsibility of the host trust.

However, the service did not monitor waiting times to ensure patients received their scan in a timely manner from arrival and identify reasons for any excessive waits.

Learning from complaints and concerns

It was not always easy for people to give feedback and raise concerns about care received.

The service did not always clearly display information about how to raise a concern. Managers told us they did not display complaint procedures in patient waiting areas or on notice boards and that this information was not available on their website.

The service had not received any complaints.

The provider's policy did not make information available about the actions a patient could take if they were not satisfied with the management of their complaint.

Are Diagnostic and screening services well-led?

Inadequate

Leadership

Leaders had the ability to run the service but did not always keep their skills and knowledge up to date with the latest guidance and practice. However, they were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The service had not complied with the fit and proper person regulations. We found that required checks had not been carried out in directors' files. Following inspection feedback, the directors provided declaration of their fitness which adhered to the requirement of the regulation.

We found that leaders had many years of experience of working in a health care setting. They told us that they kept their skills and knowledge up to date with best practice through courses and conferences, however these had not been ongoing since March 2020 due to the COVID-19 pandemic. Both directors had recently left employment with the NHS to grow the service but had not yet taken part in any further education to develop their skills as leaders.

However, the senior leadership team was approachable and visible. It consisted of two managing directors who also acted as the registered managers, they met regularly with each other and communicated directly with staff.

There were development opportunities for staff. Leaders supported staff through supervision and appraisal to identify area 's for improvement, progression and training opportunities.

Vision and Strategy

The service had a vision for what it wanted to achieve however the strategy to turn it into action and development with all relevant stakeholders had been postponed due to the COVID-19 pandemic. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The service had a vision they wished to achieve however the COVID-19 pandemic had delayed its progress. The original vision to deliver high quality, mobile MRI scanning services was postponed and management had dynamically adapted, responding to the need of local NHS services and using the NHS framework to identify demand for MRI scanning and offering the additional resource needed to address increasing waiting lists caused by the COVID-19 pandemic.

Due to the fast-changing nature of the service in response to the pandemic, evidence was not seen that all relevant relevant stakeholders were involved in the development of the companies changed remit.

Managers intended to return to the original business plan when able but did not currently have a strategy in place to initiate this or monitor its implementation. Managers monitored the financial stability of the business to ensure plans remained cost effective and sustainable.

Culture

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

Management had created a culture that respected, supported and valued their staff. For example, from meeting minutes we saw staff incentives included flexible working patterns, staff bonuses and social events that included directors. The staff survey was wellbeing focussed to ensure staff felt positive within their employment.

The service had an equality of opportunity and diversity policy in place which was in date until March 2022 with an ethos to ensure equality amongst all people and organisations they worked within. The provider was currently at tender for a new contract and had considered the demographic of the location, to meet the needs of local people, they were ensuring they had access to translation services and information in different languages before accepting the contract.

Patients' feedback was invited and was overall positive.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Governance processes were not effective and did not identify the issues found on inspection. For example, there were no records audits to ensure all patient information had been captured, therefore it had not been recognised that records did not document implied, written or verbal consent of contrast agents in line with provider policy.

The provider did not always have records and clinical audits in place. The provider's audit schedule had one records audit conducted annually, this had not been carried out at the time of inspection. There were no other records audits to identify essential patient information was being accurately recorded, for example the completion of MRI safety checklists. The provider's audit schedule had one clinical audit to ensure image quality, there were no other audits in place to ensure staff were following national guidance.

The provider did not have a system in place for staff to escalate information to the host trust in line with the service level agreement. The provider had an agreement in place which outlined the responsibility of the service to escalate maintenance and equipment faults to the host trust. The provider did not have a process in place for staff to check, record and escalate potential or actual faults.

The provider did not have a process in place to assure themselves audits were completed and actioned appropriately. Staff were required to conduct an electronic audit of the resuscitation trolley. The provider did not have a process in place to ensure that these checks took place daily and any omissions had been escalated in a timely way.

However; the provider ensured the quality of the images they were producing through regular audit. The provider regularly selected a sample of MRI images taken by radiographers over a month's period and analysed the quality of the image. Analysis was drawn for and potential reasons an image may not have met an acceptable standard and actions and learning shared with staff.

The provider conducted audits to ensure patient comfort. Managers audited scans that were terminated due to claustrophobic anxiety, only 1.2% of scans required cancellation for this reason.

Staff were clear about their roles and responsibilities and discussed these through appraisal

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The risk register did not always reflect the risks we found on inspection. For example, the register did not identify the risk that those who did not have other employment with an NHS trust may not have access to all required training. We found that one staff member, not employed by NHS, did not have complete mandatory training. However, we saw that risks on the register were rated by impact, had actions to mitigate risks that were assigned ownership and had a date for completion. There was no evidence of a process to monitor the mandatory training of staff including safeguarding. The provider did not provide mandatory training to staff. The provider told us staff training was provided by the NHS trust for which they held substantive employment but had no formal process to capture this information. One staff member employed from outside of the NHS did not have all required mandatory training modules such as information governance, this had not been identified or addressed by the provider.

Managers did not assess staff's competency to administer PGD's in line with best practice guidance and did not have a process in place to ensure that training and competencies to administer PGD's had been completed by staff's substantive employer.

However, staff had opportunity to contribute to decision making through team meeting minutes on factor such as costing to ensure quality of care was maintained.

Managers were able to dynamically adapt the business to unforeseen circumstances. During the COVID-19 pandemic the service had struggled to implement its original business plan effectively but had responded to the demand of the NHS and provided staff to address increasing waiting lists. Managers were both trained radiographers and acted as contingencies in the event of staff sickness. We did not see a business continuity plan in relation to the equipment and environment as their maintenance and therefore contingency plans were the responsibility of the host trust.

Information Management

The service did not collect reliable data and analyse it. Staff could not find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. It was not always evident whether data or notifications were consistently submitted to external organisations as required.

Management had not developed nor had access to quality dashboards to support them in collecting reliable data and analysing it. The service had no means of collating and comparing audit results. Managers did not have a process in place to ensure they had access or oversight of incidents that occurred during their MRI lists as staff uploaded these to the host trust incident reporting system.

Managers made notifications to the Care Quality Commission in line with their statutory duty. The service had notified CQC of one event. However, managers did not have oversight of all incidents as these were documented using the host trust's incident reporting system, therefore they could not be assured that any notifiable incidents were reported as needed.

However, the staff used the patient database of the host trust, this meant the sharing of patient information and scan images was instantaneous with the trust.

Engagement

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

The service provided regular, experienced and flexible staff to the host trust to help them plan and manage its waiting lists of which both parties understood their roles and responsibilities. The service received regular notifications from the NHS framework to identify MRI demand and offered support when able.

The service conducted staff surveys that related to their wellbeing. The provider obtained patient feedback surveys and analysed these for areas of improvement. In audits of 93 scans, three patients identified areas of which the provider could improve the scan experience, these were investigated by the provider and actions implemented.

Feedback was overall positive with patient sharing comments such as, "Fantastic staff, really put you at ease when I was nervous!" A key aspect of the service was its ability to collaborate with NHS trusts by offering procedures to help reduce waiting lists and times.

However, meetings did not cascade all relevant information between management and staff. Meetings used to discuss clinical governance, risks and audits were not attended by all staff. Meetings did not demonstrate how key risks and audit findings would be discussed with staff. There was no agenda item in all meetings for staff and management to discuss up to date best practice guidance and legislation. However, team meetings minute did show discussion about issues that could affect the service such as staffing, equipment and costs.

Learning, continuous improvement and innovation

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

The service demonstrated a willingness to participate in improving services and encouraging innovation. Managers had developed a children's animation, in collaboration with an NHS trust, to support their understanding of the MRI process. Although children's books were also available, management told us that they wanted to deliver information in modern way and a format that children were very familiar with. As managers owned rights to the animation, they used this format for children's understanding in InPhase practice but also shared with the host trusts they delivered services to, stating it was more important to help children's understanding than selling the product for profit.

There were limited or no opportunities for the service to participate in research as the service supported the further patient pathway, as described above, and therefore it would be difficult to encourage innovation in what were established procedures.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed • The service did not ensure that there was a system and process used to confirm that individuals, employed for the purposes of carrying on a regulated activity, satisfies the necessary requirements, and was monitored for completeness. (Regulation 19(2))

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints • The service did not establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints. Information was not available to the complainant about how to take action if they were not satisfied with how the provider manages or responds to their complaint (Regulation 16)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors • The service did not ensure that there was a system and process used to confirm that individuals, appointed as a director of the service provider or someone performing those functions, satisfies the necessary requirements, and was monitored for completeness (Regulation 5 (2))

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service did not have systems and processes such as regular audits of the service provided and must assess, monitor and improve the quality and safety of the service. (Regulation 17 (2)(a)) • The service did not maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user. This did not include decisions taken in relation to the care and treatment provided and consent including when consent changes and why the person changed consent (Regulation 17 (2)(c)).