Medical Imaging Partnership

Quality Report

Unit 7, The Pavillions
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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?	Requires improvement
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

Medical Imaging Partnership (MIP) has provided a mobile magnetic resonance imaging (MRI) scanning service since 2010 at Crawley hospital. In 2019 MIP has one relocatable scanner at Crawley Hospital, West Sussex.

In addition, a mobile ultrasound service is provided at the Vale Medical Centre, Haywards Heath. The ultrasound scans are performed by a consultant radiologist who holds practising privileges with MIP.

The mobile services provided by MIP at Crawley and at the Vale involve diagnostic assessment of patients referred under contracts with local NHS trusts, a local social enterprise organisation and a local pathway for musculoskeletal patients from Central Sussex, private patients both insured and self-pay.

The mobile services are managed from the MIP Head Office in Pease Pottage. This site also hosts the Referral Management Centre, Picture Archiving and Communication System and the logistics department which oversees radiology reporting, logistics and scheduling.

At the time of inspection, only the relocatable scanner at Crawley was in use. The mobile MRI scanner (MIP02) was not in use by MIP. It had been leased out and the plan was that the relocatable scanner would be returned and in place at the Crawley site later in 2019.

We inspected the service under our independent single speciality diagnostic imaging framework, using our comprehensive inspection methodology. We carried out an announced inspection on 17 July 2019.

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.

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

Services we rate

We rated this service as **Good** overall.

We found good practice in relation to diagnostic imaging:

- The service provided mandatory training in key skills to all staff.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service had suitable premises and equipment and looked after them well.
- Staff completed and updated risk assessments for each patient.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment.
- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff assessed and monitored patients regularly to see if they were in pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them.

Summary of findings

- The service made sure staff were competent for their roles.
- Staff of different kinds worked together as a team to benefit patients.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Patients were treated with dignity and respect. The interactions we observed showed staff being professional and compassionate. We heard staff speak to patients in a friendly yet professional manner.
- Referrals were responded to rapidly. Patients could be offered immediate appointments in case of an emergency.
- Timely reporting was monitored and facilitated with information technology systems allowing results to pass quickly to referrers. Urgent or unexpected findings triggered an immediate process, ensuring results were seen promptly by consultants.
- Corporate functions supported clinical activity at site level with policies, procedures, resources and effective communication cascaded to ensure that provision met objectives for patient care.
- We found an open and candid approach to incident and complaint management. Staff we talked with understood their role to ensure duty of candour was routinely applied.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

We found areas of practice that required improvement:

- Only 33% of staff had received infection prevention control training.
- Staff were not aware of protected time arrangements to complete mandatory training.
- Daily cleaning records were not signed and updated regularly.
- Safety checks were not signed and updated regularly.
- There were no hand sanitizers or hand washing sink for patients and visitors in the unit.
- Equipment such as needles and syringes were kept on the premises despite not being necessary for the provided procedures.
- Equipment on the unit did not always have a magnetic resonance (MR) safety label on them.
- Of the 12 policies we reviewed 8 were outdated and in need of review.
- The service was in the process of embedding a formalised staff annual appraisal programme. Although this programme was in place for the last four months not all members of staff had a designated date for their appraisal. Completion rates were below the expected standard of 100% completion.

Nigel Acheson
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	The provision of MRI scanning services, which is classified under the diagnostic imaging and endoscopy core service was the only inspected service at this location. We rated this service as good overall.

Summary of findings

Contents

Good

Medical Imaging Partnership

Services we looked at:
Diagnostic imaging

Summary of this inspection

Background to Medical Imaging Partnership

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The mobile services are managed from the MIP Head Office in Pease Pottage. This site also hosts the Referral Management Centre, Picture Archiving and Communication Service and the logistics department which oversees radiology reporting, logistics and scheduling.

The mobile services provided by MIP at Crawley and at the Vale involve diagnostic assessment of patients referred under contracts with local NHS trusts, a local social enterprise organisation and a local pathway for musculoskeletal patients from Central Sussex, private patients both insured and self-pay.

The unit has had a Registered Manager in post since March 2019. We inspected this service on 17 July 2019. This was the first inspection since Registration in 2014.

Our inspection team

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

Information about Medical Imaging Partnership

The Medical Imaging Partnership unit is a magnetic resonance imaging (MRI) diagnostic service which undertakes scans on patients to diagnose disease, disorder and injury. The service has a relocatable scanner and is located within Crawley Hospital.

Medical Imaging Partnership is registered to provide the following regulated activities:

• Diagnostic and screening procedures.

We spoke with four members of staff including radiographers and senior managers. We spoke with five patients. We also spoke with the receptionist team at the main hospital site

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the first time the service was inspected since registration with CQC. We found that the service was requires improvement for safe and good for caring, response and well led. We do not rate the effective domain for this core service.

Activity (November 2017 to October 2018):

- The service undertook 8091 scans during the period between June 2018 and July 2019.
- The service employed a unit manager, lead radiographer, and five radiographers.

Track record on safety

- No never events
- Clinical incidents: 1 clinical incident in the last year
- No serious injuries

Summary of this inspection

- One notifiable safety incident that required duty of candour in the last year.
- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA)
- No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-Coli
- There was one formal and three informal complaints about the service between April 2019 and July 2019

Services accredited by a national body:

- The Royal College of Radiologists and College of Radiographers 'Imaging Services Accreditation Scheme' - Full reaccreditation received on 18th January 2019

Services provided at this location under service level agreement:

- Confidential waste
- Interpreting Services
- Meet & greet
- MRI maintenance
- Non MRI equipment maintenance
- Waste disposal (clinical & non clinical)

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?

Requires improvement

We rated safe as **requires improvement** because:

- The mandatory training record for infection prevention was 33%.
- Staff were not aware of protected time arrangements to complete their mandatory training.
- Moving and handling training did not have a practical component in line with regulation.
- Staff did not consistently sign and update the daily cleaning records.
- Staff did not consistently sign and update safety checks.
- There were no hand sanitizers or hand washing sink for patients and visitors in the unit.
- Equipment such as needles and syringes were kept on the premises despite not being necessary for the provided procedures.
- Equipment on the unit did not always have an MR safety label on it.
- The cleaning cupboard contained open electrical circuits and chemicals for cleaning and was left unlocked. This was easily accessible to patients and posed adverse risks to patients' safety. The door had a lock however, staff could not locate the keys. We raised our concerns with the leadership team following our inspection and the cleaning products were placed in a more suitable locked cupboard and the storage cupboard was locked.

However:

- Staff demonstrated awareness of safeguarding and knew how to report concerns. The service had policies in place to support staff.
- The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff completed comprehensive risk assessments for all patients and visitors to the unit. These were recorded in a safety questionnaire and patients' risk assessments were stored in patient records.
- The unit had equipment risk assessments for the scanner and fire.
- Staffing levels and skills mix were planned and reviewed appropriately.

Summary of this inspection

- Records were stored safely and kept confidential.

Are services effective?

We do not rate effective, but we found:

- Care and treatment was delivered in line with current legislation and nationally recognised evidence-based guidelines. Policies and guidelines were developed in line with national guidelines and legislation.
- The service paid due care to patients' pain.
- The service worked well with internal colleagues, and external stakeholders such as GPs, referrers, NHS hospitals and the host hospital.
- Staff had the skills and experience to safely perform scans on patients. Staff were encouraged and given opportunities to develop.
- Staff were aware of how to seek consent from patients and consent was sought during the patient safety questionnaire for all patients.
- The unit was open five days a week, Monday to Friday 7.30am to 8pm. Management reported there were plans to increase the opening hours by opening on Saturdays to meet demand as necessary.

However:

- Not all staff had received a yearly appraisal.

Are services caring?

Good

We rated caring as **good** because:

- Staff treated patients with respect, dignity and compassion and ensured their privacy was maintained.
- All patients we spoke to gave consistently positive account of their experience with the unit and its staff. They told us staff were professional, polite and courteous.
- Staff supported patient's emotional wellbeing in a way that minimised their worries and scan related anxieties.
- Patients, relatives and carers were given information in a way they understood.
- The service encouraged patients to participate in their care and treatment and took time to address their concerns.

Are services responsive?

Good

We rated responsive as **good** because:

- People's needs were met through the way services were organised and delivered.

Summary of this inspection

- People's individual needs were identified, and their choices and preferences were considered prior to booking.
- Patients had timely access to diagnostic imaging scanning. The service was responsive to urgent referrals.
- The service used the learning from complaints and concerns as an opportunity for improvement. Staff could give examples of how they incorporated learning into daily practice.

Are services well-led?

Good

We rated well-led as **good** because:

- Leaders had the skills, knowledge and experience to manage the service.
- The provider had a clear vision and a set of values, with quality and safety as the top priorities.
- The service had a positive culture that was person-centred, open, inclusive and empowering. Leaders, managers and staff had a well-developed understanding of how they prioritised safe, high-quality, compassionate care.
- There were governance frameworks that supported the delivery of good quality care. The service undertook quality audits, and information from these assisted in driving improvement and giving all staff ownership of things that had gone well. Action plans were identified on how to address things that needed to be improved.
- Management systems could identify and manage risks to the quality of the service. The service used the information to drive improvement within the service.
- Electronic patient records were kept secure to prevent unauthorised access to data. Authorised staff demonstrated they could be easily accessed when required.
- There was a focus on service development and innovation. Leaders, managers and staff considered information about the service's performance and how it could be used to make improvements and improve innovation within the service.

However:

- We found policies that were outdated and in need of review.
- The service was in the process of embedding a formalised staff appraisal programme, but this fell below the expected standard of 100% completion.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Diagnostic imaging

Safe	Requires improvement
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Requires improvement

We rated safe as **requires improvement.**

Mandatory training

- **The service provided mandatory training in key skills to all staff. However, training completion rate for some modules was low.**
- All staff, including bank and agency staff, were required to complete their mandatory training in line with the providers 'Mandatory and Statutory training' policy, which was created in July 2019. There was a process in place to monitor mandatory training compliance and the registered manager was responsible for ensuring all staff were up-to-date on their mandatory training. Staff we spoke with who had not yet completed their mandatory training, told us there was a strict deadline to complete them. Staff were reminded to book their training promptly. However, staff on the unit could not access the mandatory and statutory training policy.
- Staff did their mandatory training online. Staff completed 17 mandatory training modules which included, but not limited to: infection control, safeguarding level one and two (for adults and children), fire safety, lone working, bullying and harassment, conflict resolution, basic and immediate life support and manual handling. However, guidance published by the Health and Safety Executive on meeting the Manual Handling Operations Regulations 1992, advises practical work as part of the manual handling training, to allow the trainer to identify and put right anything the trainee was not doing safely.
- Staff were not aware of protected times to complete their mandatory training during working hours. Staff told us they would access and complete their training on their own time outside of work, or on their days off. However, the registered manager told us that staff had protected time for training with a dedicated timeslot for questions and answers and online training every Monday morning. Additionally, we were told rostered days were used so new staff could undertake their mandatory training. We were also told that overtime was paid for when training was undertaken on days off.
- Data submitted to us following our inspection showed that there was 100% training completion for fire safety, health and safety, alcohol and drug awareness and general data protection regulation training. However, the completion rate for infection control and conflict resolution was low with 33% and 50% completion rates respectively.
- The training compliance record showed that four out of six staff had completed their resuscitation training for adults and paediatrics. Staff who had not yet completed their training had booked them. Staff we spoke with knew what their responsibilities were and could confidently demonstrate what they would do if a patient needed resuscitation.

Safeguarding

Good

Diagnostic imaging

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse.**
- The service had a 'Protection of Adults at Risk Policy' and 'Child Protection Policy' which were due for review in September 2018 and October 2018 respectively. The policies provided a framework for staff on how to identify, respond to and report all safeguarding concerns. Both policies were stored on the computer system and were easily accessible to staff.
- Safeguarding adults and children training were part of the mandatory and statutory training. We saw that four out of six staff had completed safeguarding levels one and two for adults and children, and the other two members of staff had booked their training. This met the intercollegiate guidance: Safeguarding Children and Young People: Roles and competences for Health Care Staff (March 2014). This guidance requires all clinical and non-clinical staff who have any contact with children, young people and or parents/ carers should be trained to level two.
- Staff knew what safeguarding was and their responsibilities to safeguard people from harm and abuse. Staff told us that if they identified a safeguarding concern, they would immediately escalate this to the safeguarding lead, who had a level three safeguarding training. However, not all staff understood Gillick Competence. Gillick competence is the principle used to judge capacity in children to consent to medical treatment, which was necessary to safeguard children from harm and abuse. Staff we spoke with told us if a child attended an appointment with a parent, they would always ask a parent for consent.
- All staff were checked against the disclosure and barring service (DBS) when they commenced their employment. The service had a system in place to monitor staff suitability for their role and flag up any concerns throughout their employment.

Cleanliness, infection control and hygiene

- **The service controlled infection risk. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, patients did not have access to hand sanitiser and cleaning records were not updated and signed regularly.**
- The service had an updated 'Infection Prevention and Control' policy which outlined how the risks of infection to staff and patients would be managed. The radiology manager was the infection control lead and had overall responsibility for ensuring staff adhered to the infection control policies and procedures daily.
- The MRI environment was visibly clean, tidy and free from clutter. Staff were responsible for cleaning the MRI unit and were responsible for completing a cleaning record daily. However, during our inspection we observed staff did not always complete the daily cleaning record. We raised this with the staff and were told by the lead radiographer that it was a standard practice to always clean floors and wipe down surfaces even though this was not always recorded.
- The unit did not report any healthcare related infections in the last 12 months. We were informed prior to our inspection that there were no sharps on the unit. However, on inspection we saw needles and syringes inside the emergency cupboard. The registered manager told us that the relocatable unit was supplied as an all-inclusive unit by an external provider, which included sharps and injection pumps as a standard.
- The service did not produce clinical waste. There was a domestic waste bin on the unit, and single use items such as eye masks and ear plugs were disposed of in the domestic waste bin. The unit had an emergency spill kit in case of a chemical spillage. Collection of this waste was managed under a service level agreement.
- The service had a cleaning cupboard which could be accessed via one of the patients changing cubicles. The cleaning cupboard contained open electrical circuits and chemicals for cleaning and was left unlocked. There was no risk of direct contact between the cleaning products and the electrical circuits however, these were easily accessible to patients and posed adverse risks to patients' safety. The door had a lock but was not locked. Staff could not locate the

keys. We raised our concerns with the leadership team following our inspection and the cleaning products were placed in a more suitable locked cupboard and the storage cupboard was locked.

- We observed all staff were 'bare below the elbows' in clinical areas. This reduced the risk of infection to patients and staff and was in line with good practice.
- Personal protective equipment such as gloves and aprons were available on the unit and we observed staff using gloves when cleaning equipment.
- Staff controlled infection risk well and minimised the risks of cross-contamination. We observed staff wiping reusable equipment such as radiofrequency coils (radiofrequency coils are essential for producing high quality images) using disinfectant wipes after every use. Staff replaced the bedding on the scanning table with clean fresh beddings and wiped down surfaces after every patient scan.
- The service had not carried out any hand hygiene audits in the last 12 months. We saw a poster of 'five moments of hand hygiene' on the wall next to the sink. Staff had alcohol hand gels and used them regularly before and after attending to patients. However, there were no hand sanitizers or wash sink for patients on entering or leaving the unit. This was not in line with guidelines from National Institute for Health and Care Excellence (2012): Healthcare-associated infections: prevention and control in primary and community care – 1.1.1 general advice.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment did not always keep people safe.**
- Medical Imaging Partnership shared the patient and visitors waiting area with the hospitals' urgent treatment centre under a service level agreement. All patients and visitors to the MIP MRI unit reported to the urgent treatment reception where reception staff offered a 'meet and greet' service. The reception had ample seating area with two toilets, both with disabled access. There was a separate waiting area for children which was key-coded.
- The relocatable unit was located at the carpark across the road opposite the urgent treatment centre. Patients and visitors were collected by MIP staff and escorted to the unit for their scan. Access to the unit was via a ramp which was wheelchair compliant and entry into the unit was with a key card or an internal push button.
- The MRI unit had a control room, a scanning room, and two patient changing cubicles with lockable cupboards where patients could store their personal belongings, such as wallets and mobile phones.
- There was a single MRI scanner with associated coils which was commissioned in 2019. Fringe fields were displayed on the unit (The fringe field is the peripheral magnetic field outside of the magnetic core. Depending on the design of the magnet and the room, a moderately large fringe field may extend for several metres around, above and below an MRI scanner). During our inspection, we saw the fringe field diagram where the fringe field extended beyond the container housing the scanner over the access ramp to the unit. This was raised with staff, lead radiographer and the registered manager. We have since received confirmation that the fringe field diagram we observed did not consider the magnetic shielding of the unit. We were assured by the MR advisors report that the static magnetic field was contained within the unit as the 0.5 mT field line did not extend beyond the walls of the unit. With regards to the risks associated with a large static magnetic field, the unit was considered safe and further risk management strategies would not be required for the area outside of the unit. We were provided with assurance an updated diagram has been provided and displayed at the unit.
- The service did not always label MRI equipment in line with the MHRA guidelines: Safety Guidelines for MRI Equipment in Clinical use 2015, which requires that all devices brought into the MR environment must have a safety marking such as MR Safe, MR conditional or MR unsafe. We saw a fire extinguisher in the control room which was labelled non-magnetic and an injectable pump in the scanning room did not have an MR safety label on it. Staff used a clipboard which had a metal clip for taking patient details and was not labelled for MR safety. Staff told us that they never took the clipboard into the scanning room.
- Equipment, such as the MRI scanner was serviced and maintained under contract by an external provider.

There was an updated risk assessment in place and there was an effective system for recording all faulty equipment. There had been four cases of machine breakdown which had resulted in cancellation of appointments in the last 12 months.

- Staff did daily and weekly quality checks on the MRI machine and equipment; however, this was not always signed and documented. Records showed that staff did not always monitor the room oxygen level and the helium gas (necessary to cool the magnetic coil) leakage which may result in a quenching as recommended under guidance for designing facilities for diagnostic imaging (HBN06-13.6). Quenching occurs when the temperature of the MRI machine increases significantly that it shuts off when proper safety protocols were not followed, such as checking the leakage or release of helium gas. The helium gas could in turn displace the room oxygen which could compromise patient safety.
- During our inspection we saw that staff did a regular weekly quality assurance check on the intravenous injection pump. This was despite this service not performing contrast MRI's. The intravenous injection pump was part of the unit's lease agreement.
- There was an emergency kit which contained needles, spare torches and resuscitation equipment, an automated external defibrillator (AED) which were checked daily to ensure were in good working condition in case of an emergency. The AED was easily accessible, and staff knew where it was.
- The service had a closed-circuit television system for monitoring people visiting the unit, and an emergency backup generator which ensured patient scans continued in the event of a power cut.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**
- The service had a 'Management of Clinical Risks' policy which was due for review in October 2018. The policy outlined the identification, management and reporting of clinical risks, including roles and responsibilities of every staff member.
- Patient risk assessments were done continually throughout their appointments. Initial risk assessments were done at the booking stages to identify patients with specific risks such as those at risk of falls due to poor mobility and those that could not consent to care due to a learning disability or patients living with dementia.
- Staff carried out safety checks on all patients and visitors to the unit. Patients and relatives were asked to fill out an MRI safety questionnaire to identify people who may be at risk, such as those who had metal implants or women who may be pregnant.
- The service had adopted the Society and College of Radiographers 'Pause and Check' process which is a six-point checklist that ensured the right patient received the right treatment at the right time. We saw a 'Pause and Check' poster displayed in the control room which reminded all staff to complete the safety checklist.
- Medical Imaging Partnership had a clear process to follow in the event of a medical emergency, for example, if a patient had a cardiac arrest. The service required that all staff completed a basic life support and immediate life support training as part of their mandatory training.
- Staff knew what to do if a patient had a cardiac arrest. Staff told us if a patient had cardiac arrest during a scan the scan would be switched off immediately, the patient would be taken out of the scanning room and into the control room. One member of staff would commence cardiopulmonary resuscitation while the other member of staff called the emergency services. There was a poster in the control room highlighting the procedure for patients having a cardiac arrest.
- Staff on the unit told us the service could access emergency support from the host hospital's staff. The unit was opposite the urgent treatment centre and in the event of an emergency 999 would be called or patients escorted to the urgent treatment centre. The service had not reported any urgent transfers in the last 12 months.
- Urgent or unexpected findings triggered an immediate process, ensuring results were seen promptly by consultants, or within five days if not urgent. The service had a policy to support this process.

- The service had a fire policy and all staff were required to complete a mandatory fire safety training module. There was an updated fire risk assessment. Staff were able to demonstrate how they would respond in the event of a fire. However, there were no fire evacuation plans or posters on the unit and we did not see any signage for fire exit and assembly points. This was not in line with the Safety, Health and Welfare at Work (General Application) Regulations 2007: Safety Signs at Places of Work.
- Staff at the service where unable to clarify if the design and layout of the unit always kept people safe. During our inspection, we saw the fringe field diagram for the unit and the fringe field extended beyond the container housing the scanner over the access ramp to the unit. The fringe field's 0.5mT (5 gauss line) of the MRI scanner extended outside of the designated control area laterally on both sides and across the access ramp to the unit. The Medicines and Healthcare products Regulatory agency (MHRA): Safety guidelines for Magnetic Imaging Equipment in Clinical Use 2015, required that the three-dimensional volume of space around the MR magnet containing the 0.5mT field contour does not extend outside the designated area where an item, for example a pacemaker, might pose a hazard from exposure to the electromagnetic fields produced by the MR equipment and accessories. This was raised with staff and the lead radiographer who said they were not aware if the MR safety experts had assessed the ramps for safety of patients and visitors to the unit. We later raised our concerns with the registered manager and following our inspection received confirmation that the fringe field diagram we observed did not consider the magnetic shielding of the unit. We were then assured by the MR advisors report that the static magnetic field was contained within the unit as the 0.5mT field line and did not extend beyond the walls of the unit. The unit was considered safe and further risk management strategies would not be required for the area outside of the unit. We were provided with assurance an updated diagram has been provided and displayed at the unit.

Radiography Staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment**.
- Staff in the service consisted one lead radiographer and five radiographers. The service reported no vacancies at the time of our inspection.
- All staff were given full induction when they joined the service, including the layout of the unit and fire evacuation plans. Staff rotated between the Medical Imaging Partnership MRI unit and other Medical Imaging partnership services to cover leave and days off. It also gave staff the opportunity to be exposed to a wide range of practice in imaging techniques.
- The registered manager was responsible for planning, implementing and reviewing staffing levels and skills mix in a way that kept people safe at all times. The manager ensured staff's personal circumstance and working preferences were taken into consideration during rostering. We reviewed the staffing rota for June and July 2019 and saw that actual staffing levels met planned staffing levels.
- The service operated a 12.5-hour shift pattern for staff between 7.30am to 8pm, Monday to Friday. There were always two members of staff allocated to each scanner per shift which could be either two radiographers or one radiographer and a radiographic assistant and breaks were managed well. Staff were happy with the way the rotas were planned and frontline staff were instrumental in implementing long working days.
- The service had a 'Lone Working' policy and risk assessment process. Staff told us they do not lone work and the only time a member of staff was on their own was when the second member of staff went to collect a patient or when they went for a toilet break.
- The service had not used any agency staff in the last 12 months. A pool of bank staff was always available to cover shifts which could be either planned or at short notice, such as sickness absence or in the case of personal emergency.

Medical staffing

- The provider's medical director was a consultant radiologist who had oversight of clinical safety and the

planning and structure of services and their delivery. We were told the medical director was always available to be contacted by telephone or email to offer support when there was a medical urgency and when staff onsite required medical advice. The service also used various groups of consultant radiologists such as the neuro-radiology group, musculoskeletal group and the medical director for medical advice.

- Diagnostic imaging reports were completed by consultant radiologists with practising privileges. The service audited five percent of its reports with low level of discrepancies. There was a good working relationship between the radiologists and radiographers and the radiologists where always available to offer support or guidance when required.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.**
- The service had an updated 'Clinical and Administrative Records' policy which provided a framework on how records should be collected and managed, including the roles and responsibilities of staff in line with statutory requirements.
- We reviewed six patient records and found them to be fully completed, legible, up to date and stored securely. Records included patient identity details, consent forms, patient's medical history and referrers name and details. Electronic records were available on the units' computer system and could only be accessed by authorised staff with a username and secure password.
- Paper forms containing personal details such as the patient safety questionnaire and referral letter were kept in a cupboard in the control room. These were later scanned securely into the computer system and kept with the patients' electronic records. All paper records that were no longer required were stored in a confidential waste bag at the far end of the scanning room. This was collected once a week by an external data management company for shredding and secure disposal. The cupboard where the records were kept did not have a lock and could be accessed by visitors to the unit. However, there was always a member of staff in the room that had oversight of the documents.
- Immediately following a scan, all imaging reports were forwarded to the services' picture archiving and communication system. An email was generated which alerted the referrers that the report was available, and the referrers could download the reports securely to their patient record.

Medicines

- Medicines were not used at the Medical Imaging Partnership.
- There were no controlled drugs on the unit and the service did not use any non-medical prescribers or patient group directions (PGD). PGDs allow some registered health professionals, such as radiographers, to give specified medicines to a predetermined group of patients without them seeing a doctor.

Incidents

- **The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team.**
- The service had a comprehensive incident management reporting system in place. It allowed a review of all incidents, implemented actions and shared learning to address any issues to minimise risk of recurrence and improve quality of care delivered. The provider's 'Management of Clinical Risk' policy detailed all reportable incidents such as patient safety incidence, never events, near misses, and also provided guidance on incident reporting, investigation and management.
- Staff understood their responsibilities and were able to demonstrate how they would raise a concern, report safety incidents and near misses on the providers electronic system.
- There were no never events reported in the last 12 months. Never events are serious patient safety incidents that should not happen if healthcare

providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need to have happened for an incident to be a never event.

- There were no patient deaths or serious incidents reported in the last 12 months. Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.
- The unit reported four clinical incidents between March to July 2019; two of these were reported as low harm and two reported as moderate harm. We saw that staff were kept informed of incidents that occurred in the service. We reviewed two incidents reported by the unit and found these contained detailed information. The incidents were fully investigated, appropriate actions were documented and there were lessons learned.
- The service reported one notifiable safety incident that met the requirement for duty of candour in the last 12 months. We reviewed the incident and saw that the patient was informed of the incident, an apology was given, and the affected patient was offered support. The incident was thoroughly investigated, there was learning from the incident and lessons were shared with staff.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of any unintended or unexpected incident and provide reasonable support to that person. Staff we spoke to said that they would be honest and open and speak to patients and their families if an incident occurred. However not all staff understood the principles of the duty of candour.

Are diagnostic imaging services effective?

We do not rate effective for this core service. However, we found:

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness.**
- Radiographers followed evidence-based protocols for scanning of individual areas or parts of the body. For example, each contract with a referrer identified the protocol to be used when scanning a body part.
- Scanning procedures were up to date and referenced best practice guidance from a range of bodies including the National Institute of Health and Care Excellence (NICE). The service also used a range of guidance provided from the Royal College of Radiologists.
- The department had a variety of clinical protocols. We observed that guidance from the Royal College of Radiologists was used as a basis to develop local policy such as the local rules. The local rules were up to date, appropriate and signed by all staff working at this service.
- We saw minutes of the integrated governance committee, which reviewed recent NICE guidance on radiology.
- All new staff signed to confirm they had read and understood the policies relating to their clinical practice. The registered manager was responsible for updating staff with any changes to guidance that may impact on the unit. Prospective changes were also shared at a corporate level.

Nutrition and hydration

- **Patients had access to water and food in the main site waiting area. There were no drinks or food available within the unit.**
- Patients had access to a water, food and hot drinks machine in the host site's main waiting area.
- Staff reported that if a patient requested water while in the unit they would go to the host sites' main reception and request this.
- There were processes in place to support vulnerable patients and consider particular characteristics of patients. For example, staff told us the central referral team would identify patients with diabetes or any

other conditions that could be impacted by fasting and inform the team. This way if any delays occurred the patient would be informed and advised if remedial action needed to be taken.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain.**
- We observed staff throughout our inspection reassuring and checking if patients were comfortable or in pain during their scans. They were advised to alert the radiographer if they had any concerns. If necessary, their scan could be abandoned or postponed if they were unable to continue. Staff reported this rarely occurred.
- Patients were individually responsible for their own medication. Staff would ask before the scan if they had taken any medication.
- Staff reported if a patient was in pain they could use faster scanning techniques. However, these produced a poorer quality image. For example, a scan of the back could be reduced from 15 minutes to eight minutes.

Patient outcomes

- **Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.**
- Audits of the quality of images were undertaken at a corporate level. Any issues were fed back to local services and to individual radiographers for learning and improvement. In November 2018, the unit audited 10 images, which all met the required standard.
- All images were reported through an electronic system within which was an automated retrospective auditing programme called 'Peer Review'. All reporting radiologists had 5% of their workload reviewed and graded through this process. This was in line with The Royal College of Radiologists recommendations. All discrepancies were reviewed by the medical director and learning was shared across the organisation.
- The service reported to their national accredited governing body. The Royal College of Radiologists and College of Radiographers 'Imaging Services Accreditation Scheme' (ISAS) - Full reaccreditation received on 18th January 2019.
- Managers told us audit results were accessible to staff in the internal drive and were discussed at team meetings. Local staff took responsibility to implement recommendations and drive improvement.

Competent staff

- **The service made sure staff were competent for their roles.**
- All radiographers were registered with Health and Care Professional Council (HCPC) and met standards to ensure they were delivering and providing safe and effective service to the public. All clinical staff were required to re-register every two years in accordance with HCPC, meaning staff were expected to maintain their own continuing professional development (CPD). Staff told us professional registration was checked prior to employment, and then quarterly.
- Medical Imaging Partnership Limited provided all new staff with a two-week corporate induction programme. Progress against the induction was monitored at six and 12 weeks to ensure staff had completed the necessary modules such as fire safety, emergency alarms, internal systems and policies.
- Staff from the provider's other locations who came to work at Medical Imaging Partnership were given a local induction of the unit. Staff were given a site guide which included useful contact numbers, process on arrival to the hospital, outline of equipment checks and troubleshooting.
- New staff to the unit undertook a probationary period of three months, whereby they worked alongside a radiographer on every shift. Staff were expected to complete specific core competencies within three months of employment and advanced competencies within nine months of employment. All staff completed this, regardless of their previous employment experience.

Good

Diagnostic imaging

- Only 50% of clinical staff had received an appraisal within the 12 months prior to inspection. Management told us the appraisal process had recently been reviewed, changed and implemented. We saw plans to obtain 100% compliance within the next 12 months.
- Radiographers reported they had regular contact with consultant radiologists and referrers to discuss cases, monitor image quality and discuss any cases requiring recalls.
- Medical Imaging Partnership Limited rotated staff through other locations to expose radiographers to a wide range of practices in imaging techniques. This supported the radiographer's professional development.
- Staff told us they had the opportunity to attend relevant courses to their role and felt very supported by the organisation and managers to attend the courses.

Multidisciplinary working

- **Staff of different kinds worked together as a team to benefit patients.**
- The service had good relationships with other external partners and undertook some scans for local NHS providers. We saw good communication between services and there were opportunities for staff to contact referrers for advice and support.
- The service worked with the host hospital's reception team and felt supported by them. Staff told us they all worked well as a team and ensured patients' transfer from the waiting area to the unit went smoothly between the services.
- Staff we spoke with said they felt they could contact anyone from the main organisation anytime when they required advice. This included the Freedom to Speak Up Guardian, safeguard lead, infection control and prevention lead and the executive team.
- The organisation communicated well to benefit patients' experiences. We heard how, the central referral team and the location team could contact each other to arrange and fast track any appointments.
- We heard how staff from Medical Imaging Partnership Limited attended team meetings at the provider's main office. This offered an opportunity to share experiences and improve services to benefit the patients

Seven-day services

- Appointments were flexible to meet the needs of patients. They were available at short notice. Patients were also able to call the central referral team and request a time and date to suit their availability, which the unit tried to accommodate.
- The unit was open five days a week, Monday to Friday 7.30am to 8pm. Management reported there were plans to increase the opening hours by opening on Saturdays to meet demand as necessary.

Health promotion

- Patients who may need extra support were identified during the safety questionnaire and family members or carers were permitted to accompany them in the scanning room.
- Information and advice leaflets regarding the MRI procedure were sent to the patients through the post, along with their MRI checklist and appointment details when they booked their scan.
- The MRI unit did not contain health promotion information for patients. We did not see a provider's statement of purpose or any leaflets promoting healthy lifestyles. However, staff said they would support patients in finding health promotion if they were queried.

Consent and Mental Capacity Act

- **Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.**
- The service provided staff with training on the Mental Capacity Act which staff completed every two years. Five of the six staff members had completed this training. One member of staff was still awaiting booking onto the training to complete their training.

Good

Diagnostic imaging

- The service correctly used an MRI safety consent form to record patients' consent, which also contained their answers to safety screening. A consent policy with national guidance was available for all staff on the intranet.
- We observed staff obtaining consent to treatment and re-checking the MRI checklist to ensure the patient had understood the questions and the answers were accurate.
- Staff reported issues around patient's capacity were normally escalated upon booking the patient and additional information obtained from the patient's consultant or GP. If a patient was unable to consent, staff reported they would not go ahead with the scan and seek advice from the lead radiographer.

Are diagnostic imaging services caring?

Good

We rated caring as **good.**

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- Medical Imaging Partnership had an updated 'Privacy, Respect and Dignity' policy which was easily accessible by staff. The policy set out how the service would implement and monitor systems to ensure the privacy, dignity and security of patients were respected throughout their contact with the service. All staff members were required to complete an equality and diversity course as part of their mandatory training and they took account of peoples' cultural and personal preferences.
- The service had a chaperone policy included in the 'Privacy, Respect and Dignity' policy. The policy stated that the chaperone would ideally be a member of staff. A chaperone is a person who serves as a witness for both patient and clinical staff as a safeguard for both parties during a medical examination or procedure. Staff told us if a patient needed a chaperone, the service would ensure one was provided for them on the day of the scan. However, staff had not completed any formal chaperoning training and there was no information about chaperones on the unit.
- During our inspection, we saw that staff respected peoples' privacy, and treated people in a dignified and respectable manner. The unit had two patient changing cubicles with lockable doors, and staff afforded patients full privacy. Patients could wear their own clothes for their scan when appropriate and safe to do so. When required, staff offered patients privacy gowns.
- There was a privacy screen on the control room viewing window to ensure patients' dignity was maintained at all times. Staff told us they were proud of the kind and compassionate care they provided to patients, and the highlight of their day was being able to look after a patient while they completed their scans successfully.
- We spoke with four patients during our inspection and the feedback was positive. Patients told us staff were cheerful, kind and caring. Patients told us they had a "very good experience" from the initial telephone booking stage, where they were offered a choice of appointment dates and times, and throughout their scanning appointment. A patient told us staff were "very professional and efficient". The service participated in friend and family test to get to the heart of patients experience about the service. Patient satisfaction data for July 2018 to July 2019 showed that 95.6% of patient felt their overall experience of the service was excellent or good and that 98.8% of service users would recommend this service to their family and friends. The survey asked questions such as if patients thought staff respected their privacy and dignity, were professional and offered them support and assistance.

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**
- Patients emotions were well supported, and their concerns addressed at the booking stage and throughout their appointments. The service used a

telephone booking system, and patients who required additional time or support such as those suffering from anxiety, claustrophobia, a learning disability, living with dementia or requiring additional language support were identified early and well supported.

- Patients were sent their appointment letters by post along with an information leaflet which contained useful information to reassure them about their scans and put their minds at ease. The leaflet contained key information such as what an MRI scan was, what the possible risks were, what to expect on the day of the scan and how results would be communicated. The appointment pack included a map and directions with guidance to ensure patients had enough time to plan their journeys and attend their appointments on time to avoid distress.
- We observed staff were courteous, polite and always introduced themselves. Staff took time to explain the procedure and addressed all queries or concerns before patients were taken into the scanning room.
- Patients could attend their appointments with a relative or carer to offer emotional support and reassurance and staff told us they could stay in the scanning room if they wished, and when it was safe to do so.
- Patients were offered ear protection such as ear plugs and ear defenders. Staff also provided headphones and music when needed, to help the patient relax and to ease their anxiety. Patients could choose the songs they wanted to listen to during their scan.
- They service supported claustrophobic patients well which led to low numbers of incomplete scan. Staff told us there had been occasions when they had successfully scanned anxious patients who could not complete their scans at other services, by providing continuous emotional support and reassurance throughout their appointment.
- Staff told us that if a patient became anxious or distressed during a scan, they would stop the scan, go into the room to reassure them and ensure they were okay to continue. When they felt the patient was too anxious and it was unsafe to continue, they would stop the scan and offer emotional support to the patient. Incomplete scans were referred back to the referrer and the service would rearrange another appointment on a date and time suitable to the patient.

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- Staff communicated with patients, relatives and carers in a way they understood, and they were invited to participate in the patients care and treatment. Staff encouraged them to ask questions, raise objections or discuss any concerns they had. Staff took time to address all concerns such as explaining what the scan was for and ensured the patient understood their condition, care, treatment and supported them on how to find further information.
- Patients were able to communicate with staff throughout their scan. Patients were given a buzzer during their scan which they could use when they felt uncomfortable or when they wanted to stop the scan. Staff kept patients informed of what was being done during the scan and kept them informed of the time remaining till the scan was completed.
- Relatives and carers were allowed remain with the patient for the duration of their appointment when required. If a relative or carer had a concern during the scan, staff took this seriously and ensured their concerns were addressed without delay.

Are diagnostic imaging services responsive?

Good

We rated this service as **good**

Service delivery to meet the needs of local people

- **People's needs were met through the way services were organised and delivered.**
- Information about the needs of the local population was used to inform how services were planned and

delivered. The service provided diagnostic MRI scans for patients referred under NHS contracts which included a local musculoskeletal (MSK) service and local NHS trusts. The service also carried out insurance and self-pay scans. The service case mix was varied with predominantly MSK conditions.

- The service was accessible. It was located near established public transport routes and there was accessible car parking for patients who wished to travel in their vehicles.
- The facilities and premises were appropriate for the services that were planned and delivered. Facilities included a scanning room, a control room and two patient changing rooms. The service also shared some facilities with a host hospital, including a patient waiting area and accessible toilets. There was sufficient comfortable seating, disabled access toilets and coffee and tea services in the host site's reception area.
- Patients were provided with information in accessible formats before appointments. Appointment letters contained information required by the patient such as contact details, a map and directions. The letter also informed patients about the diagnostic screening procedure, including any preparation and contraindications. The appointment letter asked patients to call in if they had any queries.
- All appointments were confirmed prior to the patient's appointment by telephone. This helped reduce the number of 'did not attend' (DNA) and provided an opportunity for the patient to ask any questions they may have. Additionally, a telephone message reminder was sent to patients 48 hours before their appointment.
- We were told that the referral process facilitated the service's preparations should the patient have any communication or disability needs, and helped identify best ways to support patients' needs in cases of ill mental health. As this service was part of the Medical Imagining Partnership Limited's provider if a patient had significant mobility or health needs they would be referred to a nearby unit to support them.
- Staff were confident and competent assisting patients who required assistance with their mobility. We heard how patients who had identified mobility concerns were assisted coming in to the unit from the main hospital and how staff assisted patients in safe transfers to and from the scanner.
- The changing room was assessed for suitability prior to its use and provided privacy and dignity. There was insufficient space in the changing room for individuals accompanying the patient and limited space for the use of wheelchairs however, any patients that required larger areas for changing or assistance in the changing room where flagged through the central referral system and scanned at a more suitable location.

Meeting people's individual needs

- **People's needs were identified, including needs on the grounds of protected equality characteristics, and their choices and preferences and how these were met. These activities were regularly reviewed and drove service development.**
- Patients' individual needs were accounted for. Staff delivered care in a way that took account of the needs of different patients on the grounds of age, disability, gender, race, religion or belief and sexual orientation. Staff had received training in equality and diversity. They had a good understanding of cultural, social and religious needs of the patient and demonstrated these values in their work.
- The provider complied with the Accessible Information Standard by identifying, recording, flagging, sharing and meeting the information and communication needs of people with a disability or sensory loss. The main reception area had a low-level reception desk and the facility provided hearing loop technology.
- Reasonable adjustments were made so disabled patients could access and use services on an equal basis to others. All patients were encouraged to contact the unit if they had any needs, concerns or questions about their examination. The referral process also identified patients who could not access this service if they were unable to transfer from a chair to a bed with minimal assistance. The Medical Imaging Partnership Limited (MIP) central referral centre would be advised if this happened and a location that could

accommodate the patient would be found. If this was not possible, the referrer would be contacted and a suggestion of an alternate diagnostic screen would be arranged.

- The service had a system in place for managing the needs of patients living with dementia or learning disability. This allowed staff enough time to encourage and engage with the patient, as well as support the people who came with them. Staff making the referral could add an alert which related to a patient's medical condition. This was in line with NICE QS15 Statement 9: Patients experience care that is tailored to their needs and personal preferences, taking into account their circumstances, their ability to access services and their coexisting conditions.
- Patients had access to interpreters if the service was informed prior to the appointment. In a clinical emergency, the service enabled staff to use a family member to translate at the radiographer's discretion.
- We were told how Medical Imaging Partnership Limited provided support and training to clinical staff to communicate with patients, or assisted if they had questions or concerns.
- Staff listened to patient's individual needs and made them comfortable during the MRI scan. 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 radiographer and the patient. Patients were also provided with 90-degree glasses and eye masks to reduce the feeling of claustrophobia and could listen to their preferred music or radio station during the scan.

Access and flow

- **Patients had timely access to diagnostic imaging scanning.**
- The service worked closely with the host hospital to improve the quality of the service provided. The service could access other MIP MRI units, with the objective of reducing the turnaround times for patients, as well as providing flexibility to patients' location preferences.
- All referrals were processed via the Medical Imaging Partnership Limited online referral portal to the central MIP referrals management team or via telephone, fax or email. Referrals were checked to ensure contact could be made with the patient and then the referrals management team contacted the patient to offer the earliest appointment on a date and location that suited them.
- Patients had timely access to diagnostic imaging scanning. The service was responsive to urgent referrals. The average timeframe from referral to scan from May to July 2019 was 11 days. For musculoskeletal patients, which were the great majority of scans, the contractual requirement was to arrange an appointment within two weeks of the referral for routine patients and within 5 days for urgent scans. The service always met their targets for urgent referrals.
- Referrals could be prioritised by clinical urgency. Urgent appointments were accommodated as quickly as possible and arrangements made for prompt reporting. Slots were held for clinically urgent referrals up to 24 hours before the day of scanning and were offered on a first available appointment basis.
- Patients and referrers had timely access to diagnostic imaging scanning reports. The average time from scan to report from May to July 2019 was 4.29 days.
- There were 21 planned procedures cancelled or delayed for non-clinical reasons between November 2017 and October 2018. The most frequent reason for cancellation was due to equipment failure, such as scanner break down.
- Appointments ran to time. Clinical staff would advise patients of any delays as they signed in to the host site's reception. Staff would keep patients informed of any ongoing delays.
- Timely reporting was monitored and facilitated with information technology systems allowing results to pass quickly to referrers. Urgent or unexpected findings triggered an immediate process, ensuring results were seen promptly by consultants, or within five days if not urgent. The service had a policy to support this process.

Learning from complaints and concerns

Good

Diagnostic imaging

- **The service used the learning from complaints and concerns as an opportunity for improvement. Staff could give examples of how they incorporated learning into daily practice.**
- Patients we spoke with told us they knew how to make a complaint or raise concerns about the service. Additionally, a patients' guide to making comments, compliments and concerns was available in the main waiting room. Staff would also provide these to patients upon request or when staff recognised its need.
- MIP had an effective complaints and management policy and procedure. This policy covered topics such as roles and responsibilities, complaints management, duty of candour, investigation and learning outcomes. Staff were trained to acknowledge and comply with this process.
- The service reported one formal and three informal complaints from April to July 2019. The service did not formally record any compliments during this period. However, we heard both patients and referrers complementing the service.
- We saw evidence of learning and changes to the service following the complaints.
- The registered manager was responsible for overseeing the management of complaints at the service. Complaints and trends were reviewed through the MIP governance framework and reported to the executive management team and board on a regular basis. We saw evidence in the team meeting minutes that learning from complaint investigations within the organisation was discussed and recorded. Staff told us learning was shared both from on-site complaints, as well as organisation wide complaints.

Are diagnostic imaging services well-led?

Good

We rated this service as **good.**

Leadership

- **Leaders had the skills, knowledge, experience and integrity to manage the service.**
- Medical Imaging Partnership Limited was a provider of diagnostic radiology services to both NHS and private patients. The company was formed by experienced operators of clinical services and continued to have a wide range of clinical, financial and operational expertise at board level.
- The executive team of Medical Imaging Partnership Limited comprised a Chief Executive Officer, Finance Director, Medical Director and Heads of Operations for three geographic locations divided into Sussex, London and Stockport and a Chief Information Officer. All team members had experience in the imaging sector. The combined experience contained within the executive team provided assurance of knowledge, skills and experience necessary to manage the service.
- The service employed a full-time unit manager. The manager was knowledgeable in leading the service. They had a healthcare clinical background which enabled them to understand the clinical aspects of the service, as well as being familiar with Medical Imaging Partnership Limited policies, procedures and governance. They understood the challenges to quality and sustainability that the service faced, and together with the senior leadership team, had proactive ongoing action plans in place to address them.
- The registered manager was fully aware of the scope and limitations of the service, based on the size, numbers and type of staff, and type of work booked. All staff told us leaders were keen to develop the service to ensure the patients received a quality service.
- Staff we spoke with found the registered manager to be approachable, supportive, and effective in their role. They also report that the MRI lead for the unit was equally approachable and supportive of their role
- We saw there was succession planning that assured the continuity of services and sustained compassionate, inclusive and effective leadership. There was a clear identification of who was responsible for the service in the absence of the manager and how the service continued to operate in this case. Additionally, we were told of sustainable plans to renew and strengthen the leadership team for Medical Imaging Partnership Limited.

Good

Diagnostic imaging

Vision and strategy

- **The provider had a clear vision and a set of values with quality and safety as their top priority.**
- Company strategy was to ensure a safe, high quality sustainable service. They used the following as their values:
- We care – for patients, colleagues & customers, about every step of the journey
- We work as one – we can rely on each other and deliver on time
- We want to be the best – we always strive for excellence and highest quality
- We trust each other and you can trust us
- We deliver value for patients, stakeholders and customers
- Happiness matters – for patients, staff and customers
- Staff were not fully aware of the vision and values but understood the strategy and their role in achieving them.
- The manager identified three key areas in the company's strategy to ensure growth and sustainability of this service and to continue the provision of safe effective care for patients. These were based on the need to maintain a high standard of care and quality of the images produced, increase local profile and preference for referrals with stakeholders and maintain a motivated workforce at Medical Imaging Partnership.
- We saw how the service had invested in their teams, infrastructure and approach to quality, to ensure they could continue to deliver on their key quality goals. This included plans to create a waiting room annexed to the unit and plans to deliver a seven-day service.
- Medical Imaging Partnership Limited operated a collaborative approach to diagnostic imaging, working with clinicians, local NHS providers and independent providers to keep the patient at the heart of their service. The collaborative approach to imaging services was designed to future proof the service and support local pathways of care. The strategy was monitored through the integrated clinical governance meeting.

Culture

- **Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- The registered manager promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff we spoke with told us they felt well looked after, safe and enjoyed working in the service.
- Staff told us management at Medical Imaging Partnership Limited were visible and approachable. Due to the small size of the team and shift patterns, innovative ways of communicating had been introduced, including the use social media for general communication and interest groups.
- The service's culture was centred on the needs and experience of patients. This attitude was clearly reflected in staff we spoke with on inspection.
- Equality and diversity was promoted. We saw this highlighted through the equality impact statement and workforce policy. Inclusive, non-discriminatory practices were part of usual working.
- The provider had a whistle blowing policy and duty of candour policy which supported staff to be open and honest. Staff described the principles of duty of candour to us and how they attended duty of candour training. Staff were aware how they could raise concerns both informally and through the Medical Imaging Partnership Limited Freedom to Speak Up Guardian.
- Staff had regular informal meetings with their manager and MRI lead. However, only half of the staff at Medical Imaging Partnership had completed an annual appraisal. The annual appraisals process had been reviewed in March 2019 to identify continuous professional development and personal development plans. We saw an annual appraisal programme that looked to provide all eligible members of staff with an appraisal before the end of the financial year.

Governance

- **There were governance frameworks to support the delivery of good quality care. The service undertook quality audits, and information from**

these assisted in driving improvement and giving staff ownership of things that had gone well and action plans on how to address things that needed to be improved.

- We saw how relationships with referring hospitals and third-party referrers were governed and managed effectively to promote person centred care. This was evidenced through the integrated governance committee (IGC) meeting minutes.
- The IGC was attended by a clinical and operational lead, a governance lead, an information technology lead and the financial lead. Additionally, it was attended by a range of healthcare professionals with expertise in the safe provision and delivery of imaging services. The registered manager of this service was a part of, and regularly attended, this meeting.
- The IGC structure allowed for effective monitoring, review and shared learning. Feedback and actions from performance and discussion of local incidents were fed into processes at a corporate level. We saw evidence of this process in the IGC meeting minutes.
- IGC meetings were held every month, had a standardised agenda and were in-line with the agreed terms of reference. There was a standardised approach to these meetings and the minutes we looked at showed actions were reviewed appropriately and in a timely manner.
- 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.
- Information was effectively cascaded through the organisation to ensure that service provision met the objectives for patient care. This was evidenced through the recently developed governance infographs. Infographs highlighted future plans and strategies, governance procedures, risk assessments and learning from incidents and complaints.
- There were processes in place to ensure staff were fit for practice. For example, they were required to be competent and hold appropriate indemnity insurance in accordance with The Health Care and Associated Professions (Indemnity Arrangements) Order 2014.
- The service had several policies that were out of date. Some policies we saw were out of date were: the 'Service and Workforce' Policy, Management of Clinical Risk Policy, Complaints Management Policy, Protection of Adults at Risk Policy and Major Incident and Business Continuity Policy. Two policies were due for review in August 2018, two in October 2018 and one in November 2018. We were told how Medical Imaging Partnership Limited was recruiting a clinical governance manager to support the review of these policies as well as strengthening the current governance process. Additionally, we were told and saw evidence in IGC meeting minutes, how the senior management structure would support the review and update of these policies.

Managing risks, issues and performance

- **Management systems could identify and manage risks to the quality of the service. The service used the information to drive improvement within the service.**
- We saw local risk assessments systems, with a process of escalation onto the corporate risk register. We also saw there was an ongoing local risk management system in the form of a risk register. When reviewing this document on site it did not offer enough assurances with regards to rating, accountability and review of the risks. This was highlighted to the manager and MRI lead. After this feedback we were provided with an updated risk register a week after inspection where we saw that the identified risks in the document were reviewed and presented appropriate and valid risk management strategies.
- The registered manager and staff were aware of patient risk related matters, such as safeguarding, reporting of incidents, policies for safe practice and safe capacity. These documents were readily available for consultation through the site file, as well as through the Medical Imaging Partnership Limited intranet page.
- The service had agreements with external organisations to ensure risks were identified and mitigated appropriately. For example, there was an agreement with an external hospital for the support of MR advisors.

- The registered manager at the site was responsible for governance and quality monitoring. They were involved in the organisation's governance framework and sat on the Integrated Governance Committee. Performance was monitored at both 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 and mandatory training levels were monitored.
- The corporate risk register assured oversight and management of corporate risks. We reviewed the corporate risk register. There was sufficiently information to ensure the senior leadership team were aware of the risks, mitigations and timely resolution to the described risks.

Managing information

- **Electronic patient records and policies were kept secure to prevent unauthorised access to data. Authorised staff demonstrated they could be easily accessed when required.**
- The service was aware of the requirements of managing a patient's personal information in accordance with relevant legislation and regulations. The Clinical and Administrative Records Management Policy, ratified in July 2018, reflected the change in laws surrounding the updated General Data Protection Regulation (GDPR) 2018.
- Staff viewed breaches of patient personal information as a serious incident and would therefore manage this as a serious incident and escalate to the appropriate bodies.
- We were assured that the service correctly managed data and sustained data information to prevent breaches of data or information misuse. Processes ensured that information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant. The picture archiving and communication system was included in this process.
- Staff had access to Medical Imaging Partnership Limited policies and resource material through the internal computer system. This included training modules on information governance, as well as access to policies such as the Clinical and Administrative Records Management Policy and Privacy, Respect and Dignity Policy.
- The registered manager knew and identified effective arrangements to ensure data and notifications were submitted to external bodies as required.
- There were sufficient computers available to enable staff to access the system when they needed to.

Engagement

- **The service involved people, their family, friends and other supporters in a meaningful way. The service collaborated with partner organisations effectively.**
- Engagement with project groups, regular one-to-one meetings, company days and team meetings were used to obtain feedback and steer changes.
- Regular meaningful communication with commissioners on contract performance ensured service delivery met patient need. We heard how joint service reviews were also used to monitor delivery and performance with self-referrers and other organisations
- Patients' views and experiences were gathered. Patient surveys were in use and the questions offered open ended answer options to allow patients to express themselves.
- Employee engagement was measured through an annual employee survey. In response to the survey, action plans were developed and progress against the plans was measured on a regular basis.
- The service had access to a Medical Imaging Partnership Limited Freedom to Speak Up Guardian (FTSUG). The role was independent and reported directly to the CEO. The FTSUG attended the quarterly information governance meetings.

Learning, continuous improvement and innovation

- **There was a focus on service development and innovation. Leaders, managers and staff considered information about the service's performance and how it could be used to make improvements and drive innovation.**

Good

Diagnostic imaging

- The team had monthly meetings to discuss governance requirements which applied to all units. Agenda items included: incidents, complaints, scan reports, health and safety issues, delivery against the business plan, information governance issues, what went well and what didn't go so well. Issues relevant to the service were discussed and actioned as a team.
- Staff could provide examples of improvements and changes made to processes based on patient feedback, incidents and staff suggestions. For example, a new waiting area was being planned to minimise the impact of patient transfers from the host site to the unit before a scan.
- The service had an operational development plan to provide less impactful scans. We heard of three initiatives that were aimed at developing new scanning pathways for patients without the need for contrast agents.
- The service demonstrated evidence of continuous learning. Staff had recently attended the UKIO imaging and oncology conference. As a learning example it was highlighted that this conference was helping the organisation identify and implement the latest reporting models.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The service should review all equipment on the unit for safety and label them according to guidelines.
- The service should provide patients and visitors with hand cleansing mediums on the unit.
- The service should strengthen their processes for recording the completion of cleaning records and safety checks.
- The service should support staff to complete their mandatory training.
- The service should safely withdraw equipment that was not necessary for the provided procedures.
- The service should review and update all out of date policies.
- The service should support all staff to receive an annual appraisal.
- The service should compile and use data from their formal patient feedback forms to identify drivers for improvement.