Hartlepool MRI Unit

Quality Report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

Hartlepool MRI Unit is operated by Alliance Medical Limited (AML) .

The Hartlepool MRI Unit commenced service delivery in 1998 and was originally a joint venture between a private sector provider and the then local NHS trust.

The MRI services at Hartlepool have been provided by AML under a joint contract with a local NHS trust since December 2001.

The unit provides a wide range of magnetic resonance imaging (MRI) scans examinations to the NHS, and clinical commissioning groups and a small number of private patients. In addition, the unit provides breast imaging services to the regional breast screening service within the local NHS trust.

The unit is registered with the CQC to undertake the regulated activity of diagnostic and screening

Summary of findings

procedures. The site provides a service for both adults and children over the age of five years. The site operates from 8am to 8pm six days a week, with reduced opening hours during Sundays and bank holidays.

The Hartlepool MRI Unit is located in a purpose built building adjoining the main hospital radiology department.

On entering the MRI unit there is an open outpatient waiting area, occupying a reception desk, plant room and a separate office space.

The registered manager's office adjoins the reception desk area.

Patients are escorted through key coded doors into a second area, which occupies the scan room, recovery area, disabled toilets, changing rooms, and the control room.

A staff room is accessed down a small corridor, with further controlled access to the MRI plant room which houses ancillary equipment for scanner operation.

All rooms within the unit are key-coded except for the main door which is locked between 8pm and 8am.

The service provides contracted imaging to NHS funded patients. There were 7996 MRI scans performed at the service between January 2018 to December 2018; 5624 of these were commissioned by a local acute trust and 2352 were completed as part of a NHS contract for a clinical commissioning group. 299 patients scanned were under the age of 18. No patients under the age of five years were scanned.

The service had out sourced image reporting to a third party to ensure the service kept within the key business intelligence indicator for reporting turnaround times and national targets when local radiologists did not have capacity.

We inspected diagnostic imaging services at this location.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection the 29 May 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' business intelligence against each key question as outstanding, good, requires improvement or inadequate.

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

The service provided at this location was diagnostic and screening procedures.

Services we rate

We rated it as good overall following this inspection.

We found the following areas of good practice because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Services were flexible and available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work.Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear

Summary of findings

about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

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

- Not all staff had completed safeguarding adults level two training in line with intercollegiate guidance Adult Safeguarding: Roles and Competencies for Health Care Staff (2018), although it is acknowledged that the organisation planned for all clinical staff to complete level two training.

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

Ann Ford

Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	The service provided at this location was diagnostic and screening procedures. We rated this core service as good overall. There were systems to monitor safety, patient outcomes and patient experience. Appropriate, nationally referenced guidelines were used in the delivery of services including those for the control of radiation. Staff were caring, friendly and professional. The service was sufficiently responsive to make reasonable adjustments for patients with disabilities or other needs Risk, governance and operational performance was well managed. There was a cohesive and visible leadership team who were committed to developing clinically-led, highly responsive services. There was a culture of improvement and safety was a priority for this service and it was safe, effective, caring, responsive and well-led. However, Not all clinical staff had received Safeguarding Adults level two training, which was not in line with the intercollegiate guidance document (2018).

Summary of findings

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Background to Hartlepool MRI Unit

Hartlepool MRI Unit is operated by Alliance Medical Limited (AML) and commenced in 1998. The head office is located at Warwick, Warwickshire. The MRI services at Hartlepool have been provided by AML under a joint contract with a local NHS trust since December 2001.

The unit provides a wide range of magnetic resonance imaging (MRI) scans examinations to the NHS, and clinical commissioning groups and a small number of private patients. 7996 MRI scans were performed at the service between January 2018 to December 2018;

There is a registered manager (RM) in place who had been registered at the unit since 2011.

Our inspection team

The team comprised a CQC inspector who had completed the single speciality diagnostic imaging training, and a specialist advisor. The inspection team was overseen Sarah Dronsfield, Head of Hospital inspection (North).

Information about Hartlepool MRI Unit

The location was registered to provide the following regulated activities:

- Diagnostic and screening procedures.

The MRI Centre undertakes magnetic resonance imaging (MRI) scans. All staff employed at the unit are employed by AML. The site operates seven days a week between the hours of 8am to 8pm.

The Hartlepool MRI Unit is located in a purpose built building adjoining the main hospital radiology department.

On entering the MRI unit there is an open outpatient waiting area, occupying a reception desk, plant room and a separate office space.

The registered manager's office adjoins the reception desk area.

Patients are escorted through key coded doors into a second area, which occupies the scan room, recovery area, disabled toilets, changing rooms, and the control room.

During the inspection, we visited the registered site in Hartlepool. We spoke with four staff including, administrator, radiographers, and senior manager. We observed two MRI scans and engaged with patients and relatives during these procedures. During our inspection, we reviewed two patient records.

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

Activity (August 2017 to August 2018)

- There were 7996 MRI scans performed at the service between January 2018 to December 2018;5624 of these were commissioned by a local acute trust and 2352 were completed as part of a NHS contract for a clinical commissioning group.

The service did not use any controlled drugs and therefore they did not have an accountable officer for controlled drugs (CDs).

Track record on safety:

- Zero never events.
- Zero serious incidents.

Summary of this inspection

- Zero incidences of healthcare acquired Methicillin-resistant Staphylococcus aureus (MRSA).
- Zero incidences of healthcare acquired Methicillin-sensitive Staphylococcus aureus (MSSA).
- Zero incidences of healthcare acquired Clostridium difficile (C. difficile).
- Zero incidences of healthcare acquired Escherichia coli (E-Coli).
- The service had received one complaint between January 2018 and December 2018. This complaint was upheld.

Services accredited by a national body:

1. ALM had three accreditations by national bodies;

   - ISAS awarded in July 2018 and due to be renewed in July 2021

   - ISO27001 awarded in June 2018 and due to be renewed in June 2021

   - IIP awarded in March 2017 and due to be renewed in March 2020.

Services provided under service level agreement:

- Chiller maintenance
- Pump injector maintenance
- MRI scanner maintenance
- MRI Safety Advisor
- PAT testing
- Emergency Lighting testing
- Provision of and maintenance of MRI safe patient trolley

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.
- Staff completed and updated risk assessments for each patient and removed or minimised risks.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment.
- Arrangements were in place for managing medicines, medical gases and contrast media that protected patients from avoidable harm.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.
- The service used monitoring results well to improve safety.

However:

- Not all clinical staff had received Safeguarding Adults level two training, which was not in line with the intercollegiate guidance document (2018).

Are services effective?

We currently do not rate effective, we found:

- The service provided care and treatment based on national guidance and evidence-based practice.
- Staff monitored the effectiveness of care and treatment.
- The service made sure staff were competent for their roles.
- Services were available seven days a week to support timely patient care.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.
- Staff supported patients to make informed decisions about their care and treatment.

Summary of this inspection

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- All feedback we reviewed from patients was positive.

Are services responsive?

Good

We rated responsive as good because:

- 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.
- People could access the service when they needed it and received the right care promptly.
- It was easy for people to give feedback and raise concerns about care received.
- Referrals were prioritised by clinical urgency and proactively monitored to avoid potential delays.

Are services well-led?

Good

We rated well-led as good because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.
- 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.

Summary of this inspection

- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- The service collected reliable data and analysed it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- 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.

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Good

We rated this service as **good.**

Mandatory training

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

- Staff received effective mandatory training in the safety systems, processes and practices. At the time of inspection, 96% of staff were compliant with their mandatory training. Training was delivered as an e-learning module or as a face to face session when assessing competency.
- Mandatory training subjects included:
  - Fire safety and evacuation.
  - Health and safety for healthcare.
  - Equality and diversity.
  - Infection prevention and control.
  - Moving and handling objects and people/patients.
  - Customer care and complaints.
  - Basic life support (BLS) and data security awareness.
- At the time of inspection, BLS compliance for the service was 100%.
- It was a requirement for all qualified clinical staff to have immediate life support (ILS) training. At the time of inspection, ILS training compliance was 100%.
- In addition, we saw three of the staff, providing cross site cover, had completed paediatric resuscitation training and one of the radiographers was the paediatric lead for the service.
- All staff were required to complete a skills matrix which showed all training complete, including additional and mandatory training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

- The provider had systems, processes and practices in place to protect patients from abuse and staff were aware of safeguarding and how to get help so that safeguarding was everyone's responsibility. We saw that the provider had an up to date safeguarding policy, which was accessible to all staff.
- The lead for child safeguarding was the provider's quality manager, who was trained to safeguarding children level four and the lead for safeguarding adults was also a quality manager trained to level three safeguarding adults.
- Staff were trained to recognise adults at risk and were able to describe circumstances when they would make a safeguarding referral or raise an alert.
- At the time of the inspection, 37% of the total staff had been trained in safeguarding adults level one and 73% of clinical staff trained in adults safeguarding level two.

- The unit treated patients from 5 to 18. We saw 26% of staff had completed safeguarding children level one and 16% had completed safeguarding children level two. However, 85% of clinical staff had completed safeguarding children level three with the remaining two staff booked to complete the training later in the year.
- There was a system in place to ensure there were always staff members on duty with the correct level of safeguarding training. Staff had access to the safeguarding team based at the acute hospital. Patients under the age of 18 who attended the service out of hours were always accompanied by a member of staff with the correct training from the acute trust. This met intercollegiate guidance 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff '(March 2014). Guidance states all non-clinical and clinical staff that has any contact with children, young people and/or parents/carers should be trained to level two.
- Contact numbers for local adult and child safeguarding referrals were available within the unit and staff told us they regularly contact the local safeguarding team for advice regarding specific individuals accessing the service.

Cleanliness, infection control and hygiene

The service controlled infection risk well.

- Standards of cleanliness and hygiene were maintained. AML had infection prevention and control (IPC) policies and procedures in place which provided staff with guidance on appropriate IPC practice in for example, communicable diseases and isolation.
- There had been no instances of healthcare acquired infections between January 2018 and December 2019.
- All areas we visited were found to be visibly clean and tidy and the trust had systems and processes in place to monitor and eliminate the risk of infection. Clinical equipment was visibly clean and labelled providing assurance of cleanliness.
- The unit was cleaned at the end of each day. Cleaning was recorded on a daily check sheet which was reviewed by the unit manager each week. All other rooms within the unit were cleaned as part of a third party agreement with the local trust.
- The registered manager delivered training specific to the cleaning of the scan room for trust staff. This ensured only named staff carried out cleaning in the scan room.
- We saw there were alcohol hand gels available on entry into the unit and adequate supplies of personal protective equipment such as aprons and gloves.
- We observed staff to be compliant with best practice regarding hand hygiene, and staff were noted to be bare below the elbow. There was access to hand washing facilities, although there was no sink in the scanning room. We observed staff washing their hands using correct hand hygiene techniques before, during and after patient contact.
- Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO) 'five moments for hand hygiene.' These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene to reduce risk of cross contamination between patients. Results for January 2018 to December 2018 showed a compliance rate of 98%. Hand hygiene results were communicated to staff through their staff meetings, with the only area of improvement needed was improved adherence to bare below the elbow rules.
- Staff followed manufacturer's and IPC guidance for routine disinfection. We observed staff cleaning equipment and machines during this inspection and between each patient's treatment.
- We saw the provider produced an annual infection prevention and control report. We reviewed a copy of the last report dated December 2018 and saw that the unit was subject to an annual IPC audit in September 2017 and achieved a score of 91%. The internal benchmark was 90%.
- We reviewed the results of the latest patient satisfaction survey dated January 2018 to December 2018 and saw that 80% of patients felt 'very satisfied' with the cleanliness and appearance of the facility.

Environment and equipment

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

Good

Diagnostic imaging

- The Hartlepool MRI Unit is located in a purpose built building separate ground floor department located within an NHS trust and was adjoining the hospital radiology department.
- The design, maintenance and use of facilities and premises were appropriate. The layout of the unit was compatible with Health Building Note (HBN06) guidance.
- The unit had clear signage and visual prompts to assist with patients and visitors attending the service. The reception desk was low for wheelchair users and the waiting area light and airy.
- The registered manager's office adjoins the reception desk area.
- Children attending the unit did not have a separate area and there was no provision made such as toys or play equipment. Although, staff told us play specialist were requested from the day case unit within the hospital.
- A water dispenser was provided in the waiting room for patients as they required it.
- Hospital car parking was available to patients using the unit.
- There was one patient toilet facility and this could only be accessed through a second set of secure doors into the scan room corridor. Staff told us that patients requiring toilet facilities were supervised at all times.
- Toilet and changing room facilities were accessible for people with disabilities. One is larger and disability friendly with a help cord. Both have lockable doors but can be overridden from the outside by staff if there is a problem. However we noticed in one of the changing rooms that there was no emergency pull cord. We saw the provider developed a risk assessment immediately following inspection and a standard operating procedure to ensure patient safety was maintained.
- Access to the control room and the MRI scan room was secured by a key coded door lock. Opposite the scan room was a patient recovery bay. The control room was also used as a reporting office for the use of radiologists and nursing staff.
- A staff room was accessed down a small corridor with further controlled access to the MRI plant room which houses ancillary equipment for scanner operation.
- The service had a single MRI scanner and associated coils, which was commissioned in 2008. Fringe fields were displayed. (The fringe field is the peripheral magnetic field outside of the magnet core. Depending on the design of the magnet and the room a moderately large fringe field may extend for several meters around, above, and below an MRI scanner).
- There was an effective system for recording faulty equipment. All machine faults were recorded by the manager, servicing of faulty MRI machines was done by the under the service level agreement by the manufacturer.
- There was sufficient space around the scanner for staff to move and for scans to be carried out safely. Patients had access to an emergency call buzzer, ear plugs and defenders during scanning. Music was no longer routinely played during the scan due to patient expectation of music choice, but could be used if requested. Staff told us that patients often brought their own music. A microphone allowed contact between the radiographer and the patient at all times.
- The room was equipped with an oxygen monitor, as recommended in HBN06-13.64, to ensure that any helium gas leaking (quench) from the cryogen (this is a specialised type of vacuum flask used for storing cryogens such as liquid nitrogen or liquid helium), is not moving into the examination room, thus displacing the oxygen and compromising patient safety. In addition, the room was fitted with an emergency quench switch which was protected against accidental use. The magnet was also fitted with emergency "off" switches, which suspend scanning and switch off power to the magnet sub-system but will not quench the magnet. Staff we spoke with were fully aware of the emergency nature of a quench situation.
- An MRI Safe trolley was available in the scanning room should they be required to transfer a patient in the event of an emergency.

Good

Diagnostic imaging

- Patient weighing scales were available in the unit and we saw where they had been appropriately service tested. Staff told us that all patients were weighed before scanning.
- The unit had access to resuscitation equipment via a resuscitation trolley located in nearby radiology department within the NHS trust. We saw a dual checking arrangement in place to ensure stock was maintained.
- Call bells were available within the MRI scanner which patients could press if they wanted the scan to stop.
- Maintenance and use of equipment was effective. We looked at three items of equipment; they all had a sticker indicating when they had been last serviced and when the next service was due. Equipment we looked at had an up to date service record which provided information on when an item was due to be serviced.
- We saw radiation warning signs and lights were correctly located outside the clinical diagnostic imaging area. The sign on the door, explained the magnet strength and safety rules.
- There were appropriate arrangements for managing waste and clinical specimens. Dirty linen and equipment was kept separately. Clinical waste bins were foot operated and once bags were full, they were removed to a secured waste area.
- Chemical products deemed as hazardous to health were in locked cupboards or rooms that were only accessible to authorised staff.
- Spills kits, for the safe cleaning of body fluids, such as blood were readily available and waste was handled and disposed of in a way that kept people safe.
- Staff we spoke with reported that they had enough equipment to provide safe and treatment to patients.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks.

- Initial risk identification was through the initial consent and referral forms. Specific risks such as risk of falls due to poor mobility are identified on the initial forms.
- Staff used the Society of Radiographers (SoR) 'pause and check' system. To reduce the risk of referrer error. Pause and check consisted of the three-point demographic checks to correctly identify the patient, as well as checking with the patient the site/side to be imaged, the existence of previous imaging and for the operator to ensure that the correct imaging modality is used.
- We saw patients were asked to complete a safety form when requiring contrast during the scan. The form asks questions about previous contrast reactions, kidney disease, asthma, and pregnancy. The radiologist and patient review this form before treatment is given.
- The provider had developed a separate MRI safety form which is sent to the referring ward to complete. We reviewed two patient records and saw all safety forms were appropriately completed.
- Clinical staff told us they felt confident to identify and respond appropriately to changing risks to people who use services, including deteriorating health and wellbeing or medical emergencies.
- We observed reception staff checking patient safety information prior to scanning. Reception staff displayed confidence when checking potential risks such as patients with metal plates or clips which they may have forgotten to declare on the questionnaire.
- Patients that became unwell in the unit would be initially reviewed on site by the doctor if in attendance or referred to their GP. However, if the patient required more urgent treatment, they would call the NHS trust resuscitation team.
- AML require a minimum of two staff qualified in the management of medical emergencies. There were pathways and processes for staff to assess people using services that were clinically unwell and need hospital admission. Radiographers and assistant practitioners have been trained and assessed as competent against immediate life support. In addition radiographers and assistant practitioners are currently training in paediatric life support to provide the required standard of care for paediatric patients that use the service. Although no patients are sedated at the Hartlepool MRI unit.

- No patients were transferred from the location to another health care provider from January 2018 to December 2018.
- The service ensured that the 'requesting' of an MRI was only made by staff in accordance with MHRA guidance (Safety Guidelines for Magnetic Resonance Imaging Equipment in Clinical Use) (2015). The referral forms included patient identification, contact details, clinical history and examination requested, and details of the referring clinician/practitioner.
- Signs were in the waiting area and changing rooms highlighting the contraindications to MRI including pacemakers. Signs also informed patients and visitors of the magnet strength and that it was always on.
- There was a pathway for unexpected urgent clinical findings. Staff we spoke with explained the processes to escalate unexpected or significant findings both at the examination and upon reporting. The urgent report was sent to the referrer, the administration team contact the referrer to confirm receipt. The registered manager provided a recent example when a finding was escalated.
- There were robust pregnancy checking procedures in place. Radiographers checked the status of all women of childbearing age prior to examination. There was also clear signage within the department waiting areas and changing cubicles to ask patients to let staff know if there was a possibility that they were pregnant.
- There were local policies in place for the risk assessment and prevention of contrast-induced nephropathy. There were in keeping with the National Institute for Health and Care Excellence (NICE) acute kidney injury (AKI) guidelines and the Royal College of Radiologists (RCR) standards for intravascular contrast agent administration.
- Staff were provided with a debrief, or other support after involvement in any incident/accidents and annual practical medical emergency scenarios are undertaken within the department, with feedback and probable outcomes reported centrally and to the staff within the Hartlepool MRI unit.

Staffing

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

- Staff employed within the Hartlepool MRI unit were also employed to provide the MRI service at the sister MRI unit with the organisation. All staff rotated across both units and told us they enjoyed the variance of experience.
- In order to make sure that patient safety is maintained at all times, AML require a minimum of two staff qualified in the management of medical emergencies and recognition of the deteriorating patient. These staff numbers were in line with the AML 'Safe Scanning Pathway Procedure'.

Radiography staffing

- There were sufficient numbers of staff with the necessary skills, experience and qualifications to meet patients' needs. A specific staffing calculation tool developed by the provider was used to determine safe staffing numbers.
- The 'Safe Staffing Pathway Procedure' ensured the service operated safely and effectively, with the appropriate number of staff and correct skill mix levels required to facilitate safe and compassionate care.
- The service employed 5.3 whole time equivalent (WTE) radiographers, working across the two sites.
- Since November 2017, two WTE radiographers had joined the service. No radiographers had left the service.
- At the time of inspection, the service had no vacancies.
- The unit manager was also the manager for the sister site and flexed regular radiographer cover across both units to cover days off and leave. This ensured staff continuity and familiarity with the unit.
- Radiographers told us they could contact a manager for advice at any time. There was an on-call provision within the trust at weekends for diagnostic advice.
- While the service had not used agency staff within the service between January 2018 and December 2018, the service had a policy in place to support agency

staff. On first day within the department, all new staff, including bank, agency staff and contractors were taken through a local induction programme identical to that completed by permanent staff.

- Each service was managed by an experienced operational manager, supported by regional management and central support functions, to maintain 24-hour accountability for safe and appropriate staffing levels.
- The service had a 'lone working' policy and risk assessment process.
- The service had a comprehensive business continuity plan detailing mitigation plans in the event of unexpected staff shortages or unavailability.

Medical staffing

- The Hartlepool MRI unit was fully integrated into the radiology department of the NHS trust. Between the hours of 9am and 5pm here was access on-site (telephone and face-to-face) to a duty radiologist for expert medical advice. Between the hours of 5pm and 8am expert medical advice was sought from the NHS trust on-call radiologist available through the hospital switch-board.

Records

Staff kept detailed records of patients' care and treatment.

- Patients' individual care records were written and managed in a way that protected patients from avoidable harm. We reviewed two electronic patient records. Records were accurate, complete, legible, up to date and stored securely.
- All patient episodes were recorded in both the trust electronic records system and the AML electronic record system. The majority of referrals received are by electronic orders that populate the trust electronic system. It was this system that was used for all appointments, clinical information and reporting for the majority of patients. Reports once verified are available electronically to the referrer.
- As this was a dual entry process key information was checked across both systems at regular points in the patient pathway. All systems used were password protected.
- The service provided electronic access to diagnostic results to the referring hospital and could share information and images electronically, if referring for emergency review.
- A process was in place for the management and reporting of urgent scan requests and results.

Medicines

Arrangements were in place for managing medicines, medical gases and contrast media that protected patients from avoidable harm.

- Policies were in place for managing medicines, medical gases and contrast media that protected patients from avoidable harm. This included obtaining, prescribing, recording, handling, security, dispensing, safe administration and disposal.
- No controlled drugs were stored and/or administered as part of the services provided in this unit. Controlled drugs are classified (by law) based on their benefit when used in medical treatment and their harm if misused.
- Patient Group Directions (PGDs) were not used in the unit. All patients who required contrast, had a patient specific directive which had been signed by a consultant radiologist.
- Staff were trained on the safe administration of contrast media including intravenous contrast (IC). We reviewed staff competency files and saw all staff had received this training.
- Emergency medicines were available in the event of an anaphylactic reaction. We checked these medicines and found they were in date and stored correctly.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.

- There were no never events reported for the service from November 2017 to October 2018. Never events are serious incidents that are entirely preventable as

guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

- There were no serious incidents reported for the service from November 2017 to October 2018 as defined by the NHS improvement serious incident framework 2013. Serious incidents are events in health care where the potential for learning was so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to provide a comprehensive response.
- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses. Staff reported incidents using an electronic reporting system shared by the trust. The service had an incident reporting policy and procedure in place to guide staff in the process of reporting incidents. The service had recorded 18 incidents from November 2017 to October 2018. We saw 75% of these were categorised as clinical and included reactions to contrast, patients feeling unwell and failure to proceed due to patient implants or electronic devices.
- All incidents and complaints reported through the organisation's electronic risk management system were reviewed on a weekly basis by the registered manager. Quality and risk managers reviewed any actions taken and produced data as part of the business intelligence report.
- Decisions relating to organisational disclosures made both under the statutory duty of candour framework and in the wider spirit of openness and transparency were recorded within the corresponding incident or complaint record and held within the electronic risk management system. 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.
- We saw staff reported incidents as per policy for example, staff had reported errors in the booking process, any concerns about pathway delays, and confidentiality. There were thorough investigations, and all relevant staff had been involved in the review or investigation. We saw the service looked for opportunities to learn lessons from these incidents with staff attending additional training and learning being shared at staff meetings for example in response to a booking issues, improved appointment letters were devised with more detailed information for the patient were implemented.
- The registered manager shared an incident which occurred last year involving the incorrect patient attending the unit. We saw procedural changes had been made following this incident.
- Staff used The Society of Radiographers 'pause and check' system. The six-point check had been recommended to help combat these errors. Pause and check consisted of the three-point demographic checks to correctly identify the patient, as well as checking with the patient the site/side to be imaged, the existence of previous imaging and for the operator to ensure that the correct imaging modality was used. Staff said the medical physics expert (MPE) was readily accessible online or through the telephone for providing radiation and MRI safety advice.
- Relevant national patient safety alerts were communicated by email to all staff. All staff had to accept emails with mandatory information in them this evidenced that they had been read.

Are diagnostic imaging services effective?

We do not rate effective.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

- Patients' needs were assessed, and their care and treatment was planned and delivered in line with evidence-based guidance, standards and best practice. Relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and

treatment were delivered, for example, the management of transient ischaemic attack and carotid appointments which adhered to recently updated NICE pathways.

- Policies procedures and staff competence were aligned to best practice and national guidance in relation to diagnostic procedures for example: 'Your Childs General Anaesthetic' produced by the Royal College of Anaesthetists of Great Britain and Ireland 2008.
- The unit participated in a number of audits including compliance against referral and scanning pathways. Image quality was reviewed by reporting radiologists and reporting radiographers and reports produced by the registered manager monthly outlining business intelligence. We saw action plans were produced to drive improvement and ensure compliance against current MHRA guidance.
- The registered manager's extended role involves the monitoring of non-compliance areas in other MRI units within the organisation. This ensured best practice was followed and learning shared across the organisation.

Nutrition and hydration

- There were no nutrition services for patients that attended the service. However, staff had access to a selection of refreshments (tea, coffee and water) which they provided to patients when requested.

Pain relief

- No formal pain level monitoring was carried out, however patients were asked by staff if they were comfortable during their appointment and provided with anaesthetic cream when injector pumps were used
- The Registered Manager told us that patients experiencing pain due to chronic or acute conditions were supported on the general anaesthetic / sedation session at sister MRI unit.

Patient outcomes

Staff monitored the effectiveness of care and treatment.

- Information about the outcomes of people's care and treatment was routinely collected and monitored. These included patients recalled for scans, image quality and numbers of patients who do not attend.
- The manager and administration team proactively monitored these cases to ensure they are progressed appropriately. Any delays noted are flagged with the vetting radiologists to address and resolve quickly. Any potential breaches are avoided due to this monitoring.
- Staff audited and compared key elements of the referral and scanning pathway and these were benchmarked with other AML locations.
- The service had an audit schedule. The audits aimed to assist in monitoring the service and drive improvement. It involved all staff ensuring they had ownership of things that had gone well and that needed to be improved.Audits included recalled patients, BUPA audit, patient experience and quality review. We reviewed the latest action plan following the quality review audit in September 2018 and saw the provider had made several recommendations such as the policy sign off functionality within the electronic systems were to be fully implemented and all small pieces of portable equipment were to be PAT tested.
- We reviewed the action plan which supported the above report and saw that actions had been appropriately undertaken within the agreed timescales.
- In addition to these audits, we saw the provider also participated in assistant practitioner quarterly audits. These looked at the appropriateness of sequences, correct orientation and field view monitoring. We reviewed the audit dated August 2018 and saw that all criteria had been met.
- We observed administration staff co-ordinating patient bookings and saw that many appointments were made available for patients within 7 days of the request.

Competent staff

The service made sure staff were competent for their roles.

- Staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, took on new responsibilities and on a continual basis. Staff had regular meetings with their manager and a business intelligence appraisal biannually to set goals to review them.
- At the time of inspection, 100% of staff had received an appraisal in the last year and were supported through on-going supervision.
- Assurance of staff competence to perform their role within AML was assessed as part of the recruitment process, at induction, through probation, and then ongoing as part of performance and development reviews.
- Radiographers were Health and Care Professions Council (HCPC) registered and met the standards to ensure delivery of safe and effective services to patients. The HCPC is a regulator, set up to protect the public. They keep a register of health and care professionals who meet HCPC standards for their training, professional skills, behaviour and health.
- Site orientation for all staff ensured their competency to perform their required role within their specified local area. For clinical staff, this was supported by a comprehensive induction programme, competency assessment completion which covered key areas applicable across all roles, and then clinical competency skills relevant to their job role and experience such as cannulation and pump injector training.
- Ongoing staff competence was managed through the business intelligence review process, for example following a complaint, incidents or image quality audits. We saw evidence of action and improvement plans.
- Clinical staff were required to complete continued professional development (CPD) to meet their professional body requirements.
- The service operated a comprehensive mandatory and statutory training programme which ensured relevant knowledge and competence was maintained and updated throughout their employment with the organisation. Topics included equality and diversity, infection control, safeguarding, manual handling and managing violence and aggression.
- The service was committed to the continuing development of staff. Staff told us they were offered access to both internal and externally part funded training programmes and apprenticeships to support them in developing skills and competencies relevant to their career with AML.

Multidisciplinary working

Radiologists, and other healthcare professionals worked together as a team to benefit patients.

- All staff we spoke with told us that working relationships within the team were positive and a shared determination to ensure best patient outcomes.
- All unit staff, including those in different teams and services were involved in assessing, planning and delivering people's care and treatment. Staff based within the service worked closely with the referring NHS trust or commissioning group, to provide smooth pathways for patients.
- The unit also provided a breast scanning service for those patients at high risk as identified through NICE guidance.
- The registered manager attended regular trust meetings to ensure radiology practice was consistent and enabled best practice to be shared.
- Staff told us they would liaise with referring professionals to ensure all necessary information was obtained prior to the patient's arrival at the department.
- The registered manager attended the education and training subcommittee for the organisation and as such represented the unit.

Seven-day services

Services were available seven days a week to support timely patient care.

- The site operated seven days a week between the hours of 8am to 8pm. Most referrals were outpatient with a small number from the day units within the hospital.
- Emergency scanning facilities outside the opening hours of the unit was provided by a local NHS hospital.
- The unit had access to 24-hour on-call radiology support, provided through the trust and a senior manager was available in an on-call capacity out of usual office working hours.

Health promotion

Staff provided patients practical support and advice to lead healthier lives.

- Information leaflets such as 'understanding your MRI scan' were sent to patients with their appointment letters and were available in the waiting rooms. Leaflets included information about what the scan would entail and what was expected of the patient before and after the scan appointment.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. Staff had received training on mental capacity. They were aware of what to do if they had concerns about a patient and their ability to consent to the scan. They were familiar with processes such as best interest decisions.
- All young patients, where appropriate, were involved in informed consent and an appropriate explanation of the role of their MRI examination. Staff we spoke with were aware of consent in relation to Gillick competency. Gillick competence is a term used in medical law to decide whether a child under 16 years of age is able to consent.
- Consent for MRI patients was taken on the day of the procedure. The AML referral form enabled the referrer to identify that the patient lacked capacity. We saw the provider had developed a specific MRI safety screening questionnaire for those patients whom lacked capacity and consent was to be provided by a family member or referring ward.
- Staff told us if a patient lacked capacity to make decisions in relation to consenting to treatment; for example, if a person living with dementia attended the service, they would be encouraged to attend with a relative or carer who held power of attorney for health after they have been screened for safety to provide the necessary support.
- Patient care records we reviewed included consent to treatment record. We observed staff obtaining verbal consent from the patients during their interventions. Scan safety consent forms were completed by all patients prior to their scan, to record the patients' consent. These also contained patient's answers to safety screening.
- A corporate consent policy was available to staff. It was written in line with national guidance.
- The staff we spoke with were aware of the need for consent and gave patients the option of withdrawing their consent and stopping the scan at any time. Patients we spoke confirmed their consent had been obtained throughout the scanning process.

Are diagnostic imaging services caring?

Good

We rated this service as **good.**

Compassionate care

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

- Staff treated patients with dignity, kindness, compassion, courtesy and respect. We observed staff introducing themselves to patients prior to the start of an intervention and provide calm clear guidance.
- The provider sought feedback from patients through a satisfaction survey. Patients are invited (via email) to

complete a survey (PSS) following their scan appointment. We saw the registered manager reviewed all comments and developed an action plan if required.

- We reviewed the results of the most recent patient survey. We saw 17 patients had responded to the monthly survey and 98% of the comments were positive. This corroborated the positive interaction we saw between staff and patients during inspection.
- The Hartlepool MRI unit reception/waiting room has a notice board displaying the details of recent departmental business intelligence including the proportion of patients satisfied with their treatment.
- Staff understood the need to respect patient's personal, cultural, social and religious needs, and they took these into account.
- Staff took the time to talk with patients and those close to them. We observed these interactions to be in a respectful and considerate manner. They showed a sensitive and supportive attitude to patients and those close to them and explained when appointments may be running late.
- We spoke with three patients; all said they were happy with the service they had received. No concerns were raised. One patient described the service as very 'efficient' and staff as 'very friendly and professional'.
- All patients said they were treated with respect, care, compassion and respect. Patients told us efforts had been made to maintain patients' dignity.
- The unit also participated in the NHS Friends and Family patient satisfaction survey. We reviewed the results from the most recent survey and saw 98% of patients were likely to recommend the service. 90% of patients said they were very satisfied with the way staff cared for them.

Emotional support

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

- Staff understood the potential impact a patient's care, treatment or condition had on their wellbeing and on their relatives, both emotionally and socially. Staff ensured they took time to speak to patients making sure that patient's privacy and dignity was observed.
- Staff we spoke with told us that patients with a specific need such as living with dementia or learning disability would always be escorted, usually by a family member. Patients expressing heightened anxiety would be provided with additional time and the offer to visit the environment before the day of the scan, where possible.
- We saw all staff were calm and reassuring in all interactions with patients at all stages, from booking in and during the scan.
- Staff told us that additional time was made available to those patients suffering from claustrophobia to enable them time to relax.

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 recognised when patients and those close to them needed additional support to help them understand and be involved in their care and treatment and enable them to access this. This included, for example, access to language interpreters, sign language interpreters, specialist advice or advocates. We observed staff communicating with patients so that they understood their care, treatment and condition.
- Staff made sure that patients and those close to them, felt able to ask questions about their care and treatment. They gave patients time to ask questions.
- We saw the administrator reviewed potential patient safety screening information when appointments were confirmed. This supported the identification of specific needs, which may have not been shown on the referrals.

Are diagnostic imaging services responsive?

Good

We rated this service as **good**

Good

Diagnostic imaging

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.

- Information about the needs of the local population was used to inform how services were planned and delivered. The service provided MRI scanning for the local NHS trust and the local clinical commissioning group (CCG). The unit provided services through contractual agreements and a small number of private patients.
- Progress in delivering services against the contractual agreement was monitored by the NHS trust and CCG. Monitoring was reported through monthly contract review meetings with the acute trust, and measurement of quality outcomes; for example, the patient experience. Service improvements were agreed at these regular meetings.
- The extended opening hours of seven days per week 8am to 8pm gave patients a greater choice of appointment times and as a result had assisted in reduced waiting times and significant progress in scanning appointments for patients referred under the cancer pathways. At the time of inspection patients were able to receive appointments within seven days.
- Patients had a choice of appointment times and could choose to attend the other site within the organisation if this was more convenient. We saw car parking arrangements and directions to the unit were made clear to patients when they booked their appointments.
- Sedation was not available at Hartlepool MRI unit and those patients requiring these services were offered appointments at sister MRI unit.
- Information was provided to patients in accessible formats before appointments. Appointment letters contained information required by the patient such as contact details, a map and directions, health professional's name if appropriate, and information about any tests or intervention. For example, if any preparation such as fasting was required. The appointment letters were sent out, and patients were asked patients to call in if they had any queries or if they had answered yes to any of the questions on the MRI safety questionnaire.
- All appointments were confirmed one day prior to patient's appointment, by phone. This helped reduce the number of do not attend (DNA's) and provided an opportunity for the patient to ask us any questions they may have. Should a patient not be verbally contacted prior to their appointment; for example where a message was left for the patient on an answer machine, the patient was asked to call the service to confirm their intention to attend the appointment.
- The service maintained on a unit level business intelligence report. This report accessed by the registered manager showed all provider sites but could be filtered to show specific site data. The report indicated the number of patients scanned, number of parts scanned, number of patients that did not attend, cancellations and feedback forms completed.
- The business intelligence and daily check were reviewed at least weekly and an action plan was used to monitor any omissions or concerns.

Meeting people's individual needs

- Services were planned to take account of the needs of different people; for example, on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation. Staff had received training in equality and diversity and had a good understanding of cultural, social and religious needs of the patient and demonstrated these values in their work.
- Reasonable adjustments were made so disabled patients could access and use services on an equal basis to others. All patients were encouraged in the appointment letter to contact the unit if they had any needs, concerns or questions about their examination.
- Staff told us they had not received any specific dementia care training but were able to describe how support would be offered and understood how to seek assistance if required.

Good

Diagnostic imaging

- The MRI scanner was located on the ground floor, so it was accessible for all patients. There was an accessible disabled toilet in the unit and lowered reception desk.
- Interpreters could be provided if the service was informed prior to the appointment. Staff also had access to a phone translation service where appropriate.
- The unit provided information leaflets including a specific leaflet for parents of children attending for a scan.
- The service engaged with patients who were vulnerable and took actions to remove barriers when they found it hard to access or use services. For example, patients could visit the unit prior to their appointment, so they could familiarise themselves with the room and the scanner. This was offered to patients who had informed the service that they were nervous, anxious or phobic to try to assist them to manage their anxieties.
- Staff provided patients with information leaflets and written information to explain their condition. All of the information leaflets we saw were in standard font size, but reception staff told us that leaflets in braille or other languages were available upon request.
- During the MRI scan, staff made patients comfortable with padding aids, ear plugs and ear defenders to reduce noise. Patients were given an emergency call buzzer to allow them to communicate with staff should they wish. Microphones were built into the scanner to enable two-way conversation between the radiographer and the patient.

Access and flow

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

- Patients had timely access to scanning and a choice of appointments. The service was open seven days a week between the hours of 8am to 8pm.
- Referrals were prioritised by clinical urgency. If patient symptoms were deemed to be clinically urgent, these patients were often given an appointment within eight to 24 hours depending on the urgency. All two-week cancer pathway patients were scanned within eleven days to enable report turn around. Where several clinically urgent requests were received, advice was sought from a radiologist on the priority order for booking.
- The service held slots to allow for any clinically urgent patient referrals, if these were not filed by urgent cases, the service utilised these appointments for in-patients or out patients who could be contacted and attend at short notice.
- Staff told us that there was an expectation that all inpatients would be scanned within one week. The unit's performance was monitored against this rule proactively by admin staff and quality managers under a '2-week rule'.
- We reviewed a copy of the last 'turnaround time' report for the period January 2018 to December 2018 and saw that an average of nine days turnaround was consistently maintained.
- Should the need arise to add an urgent referral such as a same day appointment, then the referrer and on call radiologist discussed timescales, then either a routine appointment would be deferred (with that patient offered another appointment as soon as possible and at their convenience) or the request would be accommodated with the knowledge that the service would over-run. In the second scenario all patients affected would be kept informed of the reason and length of any delay.
- We reviewed a copy of the most recent patient satisfaction survey which showed 78% of patients were very satisfied with the choice of appointment date and time offered to them.
- The service recorded the time between when a referral to the service for a scan was received and that scan being booked. Between January 2018 and December 2018. 99.2% patients on the two week wait target were seen in two weeks, 88.2% of the urgent patients were seen within two weeks. 91% of the routine patients were seen within their target of four weeks and 96.6% of routine patients were seen within their target of 39 days.
- The percentage of routine out-patients appointed within six weeks was 96.8%.

Good

Diagnostic imaging

- We reviewed business intelligence data maintained by the unit and saw that patients referred under the cancer pathway were monitored at three different stages. Those patients seen within seven days, those seen within 10 days and those seen within 14 days. All months we reviewed showed significantly high business intelligence rates. For example, we saw those patients seen within 14 days scored 100%, for six of the last 12 months. All other months recorded over 97%
- Between January 2018 to December 2018, no planned procedures/examinations were cancelled for a non-clinical reason.
- We saw 12 planned procedures/examinations were delayed for a non-clinical reason between November 2017 to October 2018. This was due to a variety of issues. For example, a faulty port on the scan table and a blown circuit board. Staff told us all patients are offered another appointment at their convenience at either site.
- Appointments ran to time; reception staff would advise patients of any delays as they signed in. Staff would keep patients informed of any ongoing delays.
- The service submitted a monthly report to the radiology services manager at the acute trust to advise them of any issues. The report covered subjects such as staffing, activity, any issues with equipment, operational issues and improvements.

Learning from complaints and concerns

- Patients we spoke with knew how to make a complaint or raise concerns. The leaflet 'Compliments, Concerns and Complaints' was available in reception, and in all clinical rooms for patients and those close them to read. Staff told us they were happy to explain the leaflet to patients ensuring they had any contact information required to issue the formal complaint. Advice on how to complain was also available through the trusts website.
- AML had developed a 'Management of Concerns and Complaints' complaints' handling policy and all staff completed a mandatory training course on complaints management. The service operated a complaints' management procedure which aimed to identify and address concerns in a mutually satisfactory manner. Patients and those close to them were encouraged to raise any concerns or issues with staff on duty or the person in charge in the first instance. Staff were empowered to attempt to resolve concerns locally wherever possible.
- Where a patient and those close to them choose to raise a 'formal' complaint, information leaflets explaining the process and available escalation pathways were available in waiting and clinical area. Those complaints which cannot be resolved are managed under a formal three stage process, consistent with NHS processes. Formal complaints were logged and monitored using the organisations electronic risk management system. AML aimed to acknowledge all complaints within three working days and investigate and formally respond within 20 working days.
- The service received one complaint between January 2018 and December 2018, which was upheld.

Are diagnostic imaging services well-led?

Good

We rated this service as **good.**

Leadership

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

- Leaders had the skills, knowledge, experience and integrity to manage the service.
- The AML management structure within the unit consisted one on-site full time equivalent unit manager and one clinical lead, which was on site daily to assist with clinical issues, work and scan. Both senior staff worked cross site to support the Hartlepool unit.
- Both the unit manager and clinical lead were experienced and competent members of staff, who had worked for the organisation for several years. They

were knowledgeable in leading the service. They understood the challenges to quality and sustainability the service faced and had pro-active ongoing action plans in place to address them.

- We saw staff were enthusiastic and spoke positively about the leadership of the service. All staff said they had constructive and positive relationships with senior staff and offered support on a daily basis. All staff felt that managers communicated well with them and kept them informed about any changes within the unit.
- The manager was visible and approachable and was clearly proud of the team. Staff said they all worked well as a team.
- The service supported staff to develop within their roles and although staff did not received any formal time off to complete training, all staff said formally requested training had been supported.
- The organisation was committed to the continuing development of staff and offered access to both internal and externally training programmes and supervision time to develop skills and competencies relevant to their career with AML.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

- The provider had a clear vision and a set of values, with the overall aim of the organisation to provide high standards of diagnostic imaging. Quality and safety were the top priority. AML had four clear values: Collaboration, Excellence, Efficiency and learning. These values were central to all the examinations and procedures carried out daily and intergraded into staff performance reviews and development.
- We saw the provider had recently developed a 'strategy wheel', which was a tool to show staff how the organisations values were linked to the mission, vision, strategy and success.
- Staff were aware and understood what the vision and values were and understood the strategy and their role in achieving it. All staff were introduced to these core values at the cooperate induction and then through their annual performance review. All personal objectives issued at each appraisal were linked to the company's objectives. An objective is a statement which describes what an individual, team or organisation is hoping to achieve.
- The current contract for the unit was due to end in May 2019 but an extension of contract has been agreed. The unit manager recognised future challenges faced by the service. For example, the unit was working at 95% capacity and the design of the unit could be improved. For example situating patient toilets in the general waiting area. In addition the magnet scanner at Hartlepool was ten years old and heading towards the end of its working life.
- Both points had been raised by the unit manager and fed back through the integrated governance and risk board.
- The service had service level agreement to ensure the equipment was regularly serviced, although there had been a small number of cancellations due to random equipment failings.

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.

- Staff in all roles levels spoke passionately about their work, and about the quality of care delivered. Staff spoke openly about support from managers and displayed a genuine passion towards delivering high quality services.
- We observed staff working together in the unit within a relaxed and friendly environment. Relationships within the team were extremely positive and all staff we spoke with told us how much they enjoyed working there.

- The service's culture was centred on the needs of individual patient groups and reflecting the needs of the local community. All staff understood the demographics of the area and the needs of the population in which they served.
- Feedback from patients about the service they had received was acted on. If any aspect of performance within the unit fell below expectations there was a real commitment from staff to make changes.
- The service promoted equality and diversity: it was part of mandatory training, and inclusive, non-discriminatory practices were promoted.
- 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. Staff told us they attended duty of candour training.
- All independent healthcare organisations with NHS contracts worth £200,000 or more were contractually obliged to take part in the Workforce Race Equality Standard (WRES). Providers must collect, report, monitor and publish their WRES data and act where needed to improve their workforce race equality. The provider had produced a WRES report in July 2018 including data from the previous 12 months. There was clear ownership of the WRES report within the provider management and governance arrangements, this included the WRES action plan reported to and considered by the Board.

Governance

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

- There was an effective governance framework to support the delivery of the strategy and good quality care. The service undertook several quality audits, and information from these assisted in driving improvement and giving all staff ownership of things had gone well and action plans identified how to address things needed to be improved.
- AML operated a comprehensive clinical governance framework and we saw clear governance committee structures. Quality monitoring was the responsibility of the location registered manager and was supported through a number of sub committees, which are aligned to the integrated governance and risk board. This included a clinical governance committee, information governance and security committee, health and safety committee, radiation protection committee, education and learning committee and research committee.
- Local governance processes were achieved through monthly team meetings and local analysis of business intelligence, discussion of local incidents. Feedback and actions were fed into processes at a corporate level. We saw evidence of this process in clinical governance meeting minutes and team meeting notes during our inspection.
- Staff were trained and supported to ensure they were competent in incident reporting, complaint handling.
- Staff were supported in developing local policies and protocols as well as implementing corporate policies and procedures. All policies we reviewed during inspection were up to date and included national guidance and legislation. Although most of the policies were only accessible through the electronic database as the registered manager was currently updating the 'office paper file.
- 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.
- Working arrangements with partners and third-party providers were managed. For example, there was service level agreement between the service and the local NHS trust. The service provided a monthly quality reports and held regular meetings with radiology services manager at the acute trust to discuss the service provided.

Managing risks, issues and business intelligence

Good

Diagnostic imaging

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

- The Integrated Governance and Risk Board (IGRB) is a sub-committee of the overarching AML supervisory board and was established to provide assurance to the Board that appropriate integrated governance and risk management mechanisms are in place and effective throughout the organisation.
- We saw the provider had developed a 'Risk Management and Strategy and Operational Policy' which provided guidance on how risk was to be managed within the unit. Risk management was via a co-ordinated approach, supported by risk assessments and procedures, collated via the electronic risk management system.
- The policy assessment outlined a process of escalation onto the corporate risk register.The local risk register was reviewed and updated, and some new risks added. The risk register included levels of acoustic noise, lone worker scanning, manual handling, exposure of patients to rapidly switched magnetic field gradients, portable heaters and unauthorised access into the scanning room. An action log was also included identifying timescales and accountability and we saw this was regularly updated.
- We saw the provider held resuscitation simulations to ensure staff were able to manage emergency situations effectively. We reviewed documentation following the last simulation in February 2019 and stated the resuscitation response was timely and met current best practice and national guidelines.
- Quality Managers within the organisation also monitored business intelligence on a local and corporate level. Performance 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.
- The registered manager had recently been asked as part of the new management arrangements to review noncompliance areas within other units of the organisation. The improvements made would be shared with other units to drive improvement.
- The provider had developed a comprehensive programme of audits which was monitored through performance reports and discussed as actions at team meetings.
- A newsletter had been developed by the provider called 'Risky Business' which shared incidents and near miss situations arising within the organisation. We saw copies of this newsletter during inspection and all staff told us they were useful.
- Managers ensured staff did not work alone, by rostering two staff in the unit at all times.

Managing information

The service collected reliable data and analysed it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

- Electronic patient records were kept secure to prevent unauthorised access to data. Authorised staff demonstrated they could be easily accessed when required.
- Staff had access to AML policies and resource material through the electronic computer system.
- The majority of patient information was electronic with paper based safety screening questionnaires to enable patient completion.
- There were sufficient computers within the unit to enable staff to access the system when they needed to, and the manager had a laptop computer.
- Staff were able to locate and access relevant and key records easily, this enabled them to carry out their day to day roles.
- Information from scans could be reviewed onsite and remotely by authorised referrers and on call radiologists, to give timely advice and interpretation of results to determine appropriate patient care.

Engagement

- Attempts were made to gather patients' views and experiences through the patient surveys. We saw changes were implemented following feedback from patients. For example, reduction in fasting times from eight hours to five hours, short notice appointments and courtesy calls to remind patients of their appointments 24 hours before their appointment.
- Staff told us they felt actively engaged, their views were reflected in the planning and delivery of services and in shaping the culture.
- Annual employee satisfaction surveys were undertaken. These were used to seek views of all employees within the organisation and actions implemented from the feedback received. We reviewed the results of the north team's survey for 2018, which also included the Hartlepool site. Staff were asked to score up to a maximum of six points for each question presented. We saw questions relating to 'My Team', 'Quality and Safety', and 'My Work' scored high with 'Rewards and recognition' scoring the least points. As the data was combined with sister site we were unable to show exact breakdowns for Hartlepool MRI Unit.
- The service had a good relationship with local NHS trust and local commissioners. Feedback we received from commissioning colleagues was extremely positive and outlined transparent positive professional relationships. The service engaged regularly with radiology services manager at the acute trust to discuss the service provided.

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.

- Staff could provide examples of improvements and changes made to processes based on patient feedback, incidents and staff suggestion. Staff were alert to new initiatives and ways of working. For example, the service had introduced some changes to patient identification processes following a past incident.
- The team had recently been nominated by a colleague within the trust and had been shortlisted for an award.
- We saw two staff members were currently undertaking a level three leadership apprenticeship to provide adequate succession planning for leaders within the unit.
- The Hartlepool MRI unit is actively involved in the training of graduate radiographers within the MRI environment. The Hartlepool MRI unit appointed its first graduate in August 2018. The unit is also active with local universities and is able to provide extended placements in MRI for undergraduates. These two programmes assist in attracting radiographers and therefore adding to sustainability.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- Ensure all staff receive safeguarding adults training in accordance with the intercollegiate guidance document Adult Safeguarding: Roles and Competencies for Health Care Staff (2018).