York Diagnostic Imaging

Quality Report

The Biocentre
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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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Summary of findings

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

York Diagnostic Imaging is operated by University of York. The service provides diagnostic and imaging services for adults and children and young people. The service provided is limited to the use of Magnetic Resonance Imaging (MRI) and musculoskeletal (MSK) and neurological imaging.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 22 October 2018.

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

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

Services we rate

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

We found good practice in relation to:

- The service had enough staff with the right qualifications, skills, training and experience to provide the right care and treatment. All staff were up to date with mandatory training.
- The service had suitable premises and equipment and this was well maintained.
- Staff had received training with regard to safeguarding children and vulnerable adults, which included mental capacity and consent.
- Staff learned from recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team.
- The service was planned and provided in a way that took account of the patients and service users views and feedback. The service monitored the effectiveness of their service and used the findings for improvement.
- Staff were competent, had clear objectives and received regular reviews and appraisals.
- Staff worked well together as a team and with service users, patients and suppliers to benefit patients and provide a good service.
- We observed that all staff were polite and courteous to patients from arriving at the department to when they left. Patients told us they were happy with the service and that they had been talked through what to expect at every stage of the process.
- Patients told us the service was easy to access. There was no waiting list and around 80% of patients received their scan within five working days of referral.
- The service had a vision for what it wanted to achieve and identified actions developed with the views of staff, patients and service users taken into consideration.
- The service had not received any complaints in the last 12 months and was responsive to patient feedback.
- The service had systems and processes in place to minimise risks and manage issues and performance.

However, we also found the following issues that the service provider needs to improve:

- The provider must ensure that the records management, consent and safeguarding policies are reviewed in line with current best practice guidance and have any incorrect information removed or amended to ensure guidance complies with current legislation and best practice.

Summary of findings

- We were concerned that staff did not always recognise or report incidents which meant there were lost opportunities for learning and improvement.
- Policies and protocols were not always referenced or dated.
- There was no programme of audit in place to monitor compliance with policies and protocols such as infection prevention and control, or to monitor outcomes such as; image quality or appropriateness of referrals.
- There were no adaptations to the environment, such as posters, or decoration to make the environment child friendly and staff needed to consider how they would adequately meet the needs of patients who could not speak English. The service did not routinely make health promotion information available for service users.
- The service used a number of methods of receiving and transferring patient information to and from referrers which increased the risk of information loss or breach of confidentiality.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	We rated this service as good overall with ratings of good for safe, caring, responsive and well-led. CQC does not rate effective for diagnostic imaging services. There were areas of good practice and a small number of things the provider must do to improve.We issued the provider with one requirement notice. Details are at the end of the report.

Summary of findings

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Services we looked at

Diagnostic imaging

Summary of this inspection

Background to York Diagnostic Imaging

York Diagnostic Imaging (YDI) is operated by the University of York and is part of the York Neuro Imaging Centre (YNiC) The service is provided in a purpose-built clinic on the University Campus at Heslington.

The service opened in August 2014 and provides non-contrast MRI scans to self-funding patients. The service receives referrals from healthcare professionals for magnetic resonance diagnostic imaging (MRI) scans and has them reported by a third party radiological reporting service.

The service is registered to provide diagnostic and screening procedures.

The clinic's registered manager has been in post since September 2017.

York Diagnostic Imaging also carries out separately funded clinical research under the umbrella of YNiC, which is not regulated by CQC and was therefore not inspected.

Our inspection team

The team that inspected the service comprised a CQC lead inspector with additional training in the inspection of diagnostic imaging services and a specialist advisor with expertise in radiology. The inspection team was overseen by Sandra Sutton Inspection Manager.

Information about York Diagnostic Imaging

York Diagnostic Imaging is registered with the CQC to undertake the regulated activity of diagnostic imaging. The unit is located on the ground floor of the 'Biocentre' on the University of York campus. The service is accessible to people with disability.

The University of York employed the staff working at the unit. The service had recently changed to running the MRI clinic one day a week, on a Monday, from 11AM to 6.30PM with patients usually booked from 11.30AM to last appointment at 6PM. The service scans adults and children of all ages. The service does not offer MRI scans requiring the use of contrast media.

The service received referrals mainly to scan patients with musculo-skeletal (MSK) problems, from GPs and allied health professionals (AHPs) such as physiotherapists, chiropractors, osteopaths and podiatrists. The service also received infrequent referrals for brain scans.

The imaging unit includes a purpose-built suite with a static MRI scanner and control room, a dedicated reception area, changing rooms and accessible toilet facilities.

During the inspection, we visited all areas of the unit and spoke to all staff on duty including; the director of the service, the manager of imaging services, the radiographer, two assistants and one reception staff. We spoke with and observed the care of the four patients who visited the unit that day. We also reviewed information provided by the service and looked at online systems and records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. This was the clinic's first inspection since registration with CQC.

Activity (July 2017 to June 2018)

Summary of this inspection

- The service told us they performed around 350 scans a year (1400 since 1 August 2014). All patients were self-funded.

The service employed one director, one manager of imaging services, one radiographer, two assistants and three receptionists.

Track record on safety:

- Zero Never events
- Zero Serious injuries
- Clinical incidents: - There was one incident reported in the 12 months preceding the inspection, this was a no harm incident.
- Zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- Zero incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- Zero incidences of hospital acquired Clostridium difficile (C.diff)
- Zero incidences of hospital acquired E-Coli
- Zero complaints

Services provided for the clinic under service level agreement:

- Radiology reporting service

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

Are services safe?

We rated safe as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The service had enough staff with the right qualifications, skills, training and experience to provide the right care and treatment.
- The service had suitable premises and equipment and this was well maintained.
- Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- Staff had received training with regard to safeguarding children and vulnerable adults.
- Staff learned from recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team.

However, we also found the following issues that the service provider needs to improve:

- We were concerned that staff did not always recognise or report incidents which meant there were lost opportunities for learning and improvement.
- The safeguarding policy needed to be reviewed and updated in line with current best practice guidance.
- There was no programme of audit in place to monitor compliance with infection control policies such as hand hygiene and cleaning standards.
- There was no process in place for the testing of the defibrillator, or an at a glance protocol or flow chart to assist staff if they needed to raise an emergency response.

Are services effective?

Are services effective?

We do not currently rate effective for diagnostic imaging services. We found the following issues that the service provider needs to improve:

- There was some incorrect information in the consent and safeguarding policies which needed correcting as this was not in line with current legislation and best practice.

Summary of this inspection

- Although the service provided care and treatment based on national guidance, they needed to ensure policies and protocols were fully referenced, and had dates of writing and review by.
- The service did not undertake any audits regarding outcomes such as; image quality or appropriateness of referrals.
- The service did not make health promotion information routinely available for service users.

However, we also found the following areas of positive practice:

- The service monitored the effectiveness of their service and had audited the impact of a recent service change. They had used the findings for improvement.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance, staff had clear objectives and regular reviews.
- Staff worked well together as a team and with service users, patients and suppliers to benefit patients and provide a good service.

Are services caring?

Good

We rated caring as **Good** because:

- We observed that all staff were polite and courteous to patients from arriving at the department to when they left.
- Patients told us they were happy with the service and that they had been talked through what to expect at every stage of the process.
- Staff provided emotional support to patients to minimise their distress.
- Staff explained what would happen in a way patients could understand and gave them the opportunity to ask questions.
- Costs to patients were available on the YDI website so they were aware of these before or at referral.

Are services responsive?

Good

We rated responsive as **Good** because:

- The service was planned and provided in a way that took account of the patients and service users views and feedback.
- Patients told us the service was easy to access.
- There was no waiting list and from August 2017 to July 2018 78% of patients received their scan within five working days of referral.
- The service took account of patients' individual needs.

Summary of this inspection

- The service had not received any complaints in the last 12 months and treated any concerns received from feedback cards seriously. Concerns were shared with all staff and improvements made.

However, we also found the following issues that the service provider needs to improve:

- There were no adaptations to the environment, such as posters or decoration to make it child friendly.
- Staff needed to consider how they would meet the needs of patients who could not speak English.

Are services well-led?

Good

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

- The service had managers with the right skills and abilities to run the service.
- The service had a vision for what it wanted to achieve and identified actions developed with the views of staff, patients and service users taken into consideration.
- Staff were supported and managers and staff had a sense of common purpose and shared values.
- The service had an inclusive culture and staff wanted to continually improve the quality of its service.
- The service had systems and processes in place to minimise risks and manage issues and performance.
- The service engaged well with patients, staff, stakeholders and suppliers to plan and manage appropriate services.
- The service was committed to improving services by learning from when things go well and when they go wrong.

However, we also found the following issues that the service provider needs to improve:

- The service had a number of methods of receiving and transferring patient information to and from referrers which increased the risk of information loss or breach of confidentiality.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as **good.**

Mandatory training

- Staff received a number of mandatory training modules, some of which were expected by the university as their employer and some that was specific to the service. Mandatory training modules included; fire safety, diversity and equality, safeguarding children and adults and information security awareness. All staff had received basic life support (BLS) training. All staff involved in scanning also had first aid training as a minimum requirement and a number of staff also had received mental health first aid training.
- Training was online and staff told us they were up to date with their training. They told us they were given time to complete this during their working hours.
- The University of York kept a training database of statutory training requirements for employees and YDI maintained a local database of their training requirements. We saw that both systems generated email alerts when retraining was needed.
- Managers told us they received trigger emails from the IT system to let them know when staff needed to attend refresher training.
- We saw paper copies of training certificates and online records that showed 100% staff training compliance. All the radiology assistants had received training in first aid.

Safeguarding

- There was a safeguarding policy in place for children and vulnerable adults, which outlined staff responsibilities with regards discussion with senior staff and reporting to the local authority and or police as appropriate. The policy also stated requirements for Disclosure and Barring Service (DBS) checks and staff supervision if this had not been undertaken and directed staff to the University of York policy for further information if needed.
- However, the policy did not include expectations regarding safeguarding training and staff competence, it was unclear regarding who could accompany a child (this should be someone with parental responsibility) and did not reference up to date intercollegiate guidance documents for children and vulnerable adults, or working together guidance
- Staff had undertaken safeguarding training at level 2 for children and level 1 for adults. Staff had accessed this training from an online training provider. This met intercollegiate guidance: Safeguarding Children and Young People: Roles and competencies for Health Care Staff (March 2014). Guidance states all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers should be trained to level two.
- The leads for safeguarding were the director and the manager for imaging services who were trained to level 3 for children and level 2 for adults, 100% of staff

were compliant with level 1 and 2 for children's safeguarding which was appropriate for this service. All staff were compliant with level 1 training for adult safeguarding. Although this was in line with requirements, level 2 adult safeguarding training would be best practice for any clinical staff.

- At the time of inspection staff had either been checked through the DBS or worked under the direct supervision of staff who had been checked. However, the director had recently made the decision that all staff working in the unit should be DBS checked and all staff had applied to the service for clearance. Staff continued to work under supervision while waiting clearance.
- Staff told us that they scanned few children but they had recently done so. Staff told us that children were always accompanied by a parent, and the safeguarding policy stated that children must always be accompanied by a parent or responsible adult known to the child.
- The staff we spoke with demonstrated an understanding of their responsibilities with regard to safeguarding however, they had not experienced a situation where they had to raise a concern or make a referral. Staff were aware of who they needed to contact within the local authority if they had a safeguarding concern and contact numbers were available.

Cleanliness, infection control and hygiene

- The manager for imaging services was the lead for infection, prevention and control (IPC). All staff had undertaken training in IPC and hand hygiene.
- There were IPC policies and procedures in use. These provided staff with guidance on appropriate IPC practice in for example, cleaning schedules, hand hygiene and decontamination of equipment before servicing or repair. There was no information available regarding whether patients were discouraged from attending the unit if they were suffering from communicable diseases such as flu or diarrhoea and vomiting.
- There were hand washing facilities and gels, cleaning solutions, spill packs and personal protective equipment were available if needed.
- The department was visibly clean and tidy and there were cleaning schedules for the different areas of the clinic.
- A third-party contractor cleaned the communal areas of the clinics and staff were responsible for cleaning the clinic rooms. There were schedules and cleaning records in both areas to show that schedules were completed daily or weekly depending on the task.
- We saw staff using hand gel between patients and hand gel was available for patients in the reception / waiting area.
- We did not see any evidence that staff hand hygiene was audited.
- The clinic did not have any special waste disposal requirements.

Environment and equipment

- The unit was small and self-contained, with some dedicated parking spaces immediately outside. Although the door into the unit was not automatic there was doorbell for patients to use and staff would go out and help patients into the building, if needed. The unit consisted of a waiting room and reception area. There were two changing cubicles for patients and accessible toilets. A scanning observation area allowed staff to observe the patient during scanning.
- All clinical and administration areas were secure with electronic locks requiring fob access. Staff collected patients from the waiting area to take them to the changing area and MRI scanning room.
- There were fire safety signs and a fire extinguisher was accessible in the clinical area. MRI safety signs and 'no pacemaker' signs scans were visible in the corridor and on the scan room doors.
- We saw there was enough space around the scanner for staff to move and for scans to be carried out safely. During scanning all patients had access to an emergency call buzzer, ear plugs and defenders. A microphone allowed contact between the radiographer and the patient. Music or videos could be played for patients' distraction if wanted.
- There was a hand-held alarm button in the scanner that patients could press if they wanted to stop the scan for any reason.

Good

Diagnostic imaging

- An MRI safe wheelchair and trolley were available should there be a need to transfer patients in and out of the scan room.
- There was an equipment maintenance policy that covered, essential maintenance, repairs and quality assurance.
- There was a system to ensure repairs to equipment were carried out if machines and other equipment broke down. Staff told us repairs were completed quickly and there had not been any delays to patients because of breakdowns. Servicing and maintenance of premises and equipment was carried out using a planned preventative maintenance programme. There were maintenance logs that showed when equipment had last been serviced and when the next service was due. All equipment checks were in date.
- Staff told us that repairs were made quickly and due to the clinic running one day a week, in addition to appointments only being made one or two weeks ahead, there was scope for maintenance or repairs without disrupting patient appointments.
- All the equipment we viewed conformed to relevant safety standards and was serviced on a regular basis. We saw that electrical equipment was safety tested. Staff carried out daily quality assurance checks on the scanner to ensure it performed safely and to specification.
- We saw electronic records which provided evidence that daily quality assurance checks, on the equipment were carried out.
- Staff had been trained by the equipment manufacturer in the safe and effective use of the MRI scanner.
- We checked the unit's resuscitation grab bag and defibrillator during the inspection. The defibrillator, bag and its contents appeared visibly clean, however, the defibrillator pads were out of date. We removed them and asked staff to dispose of them. Replacement pads were available. There was no process in place to check the grab bag equipment was all present and in date or any records to indicate that the defibrillator had been checked and 'self-tested' regularly and was in working order. However, when we spoke to the operations manager they said they would put something in place immediately.
- Pull cords were available in areas where patients were left alone, such as toilets and changing areas.
- Staff felt they had all the equipment they needed and managers told us that if new equipment or environmental changes were needed then they could access funding.

Assessing and responding to patient risk

- The clinic radiographer screened all referrals to ensure they were appropriate and all necessary information was on the referral form. Referral forms gave the patient's clinical history, demographics, requested scan, referrer details and had ample space for the referrer to give any other relevant information. The safety forms covered implants, devices, metal fragments including in the eyes, pregnancy and recent or old surgery to head, eyes, ears and heart.
- If the radiographer felt the referral was inappropriate or they needed further information they would contact the referrer directly. The radiographer was accountable for ensuring referrals were appropriate, determining if there were any contraindications and deciding if the scan should proceed.
- The clinic kept an electronic list of approved referrers. Staff told us if a referral was received from a new referrer they would check on the relevant professional website, such as the General Medical Council (GMC) or Health and Care Professions Council (HCPC), to check their registration status. Staff told us the clinic did not accept referrals from anyone without a relevant clinical qualification / registration.
- When a referral was accepted the radiographer or delegated member of staff would ring the patient to go through the MRI scanning safety checklist over the phone. This ensured there were no contra-indications for the proposed scan and that patients were forewarned about the necessity of declaring any implants or foreign bodies that may be a patient safety risk.

Good

Diagnostic imaging

- The safety checklist form was given to patients to fill in on arrival at the clinic to double check there were no reasons why the scan should not go ahead. The patients completed this form themselves as a self-declaration which doubled as a consent form.
- On entering the scan room, the radiographer went through the safety checklist with the patient again and a metal detector was used as a final safety check before the patient entered the scanner.
- There was a MRI safety manual for operators easily accessible within the scan room, as were the MRI local rules and level of operator training status / level.
- We saw that staff followed a patient identification policy and ensured that patients were correctly identified and that referral information and body part to be examined were verified.
- The safety questionnaire and consent for procedure were also checked again with the patient before the patient entered the scan room.
- There were alarm call bells in the toilets and controlled areas. Staff told us they had been trained on how to respond to alarms.
- All staff were trained in basic life support (BLS) and staff were aware that if a patient became seriously unwell or collapsed that their emergency response was to dial 999.
- Central Alerting System emails and equipment safety notices from manufacturers were received by the director who shared them with the team, when relevant.
- There was a process in place in case the findings of an examination required urgent referral to a medical practitioner, this included if the radiographer detected an unexpected finding or if an unexpected finding was detected at reporting stage.
- MRI images were outsourced to a third-party company for reporting by consultant radiologists. The reports came back to the service and were then shared with the referrer. If there were any queries about images or reports the service liaised with the reporting radiologist and arranged direct contact with the referrer.
- The manager of imaging services gave an example of when they had done this for a patient whose referrer had picked up an unreported finding on an image. The reporting company had reviewed the image and although the finding did not have an impact on the patient's initial report / diagnosis or treatment they had made an addendum to the report.
- Staff told us they could seek medical advice if needed in relation to the imaging procedure or findings, from the referring health care professional or the reporting radiologist.

MRI Staffing

- There were enough staff with the right skills to deliver the service. Although short notice sickness of the radiographer would potentially lead to a clinic being cancelled this had never happened.
- The following staff were involved in the running of YD: The director (registered manager) and manager of imaging services were employed fulltime by the university to cover the YNiC and as part of this role they were responsible for YDI. The other staff were also employed by the university and had dedicated time for YDI as follows; a radiographer (0.4 wte), three receptionists (1.2 wte) and two radiographer assistants (0.2 wte).
- From April 2018 to June 2018 an agency radiographer had been used on six occasions to cover the radiographer post as this had been vacant. However, this vacancy had now been filled and it was no longer necessary to use agency staff.
- The service did not employ any medical staff.

Records

- The clinic kept limited patient records due to the nature of the service. Records included; the patients' referral form/ letter, safety checklist and scan report. The paper checklist was scanned onto the IT system and the paper copy was destroyed. Patients were given a unique identifier in case records needed to be retrieved at a later date.

- Records were kept in line with the principles of the Data Protection Act 1988 and the clinic had a records management policy. However, the retention period stated was 10 years which was appropriate for adults' records but not for children's records / images.
- Referrals came in via encrypted email delivery or by fax to a secure fax machine. Transfer of information between the service and the image reporting was secure. Transfer out of reports to the referrer mirrored the method of referral i.e. by encrypted email or fax delivery. The admin staff told us they ensured delivery receipts were obtained when sending and receiving information and these were also kept with the patient record. Staff told us that sometimes they needed to send hard copies of reports and also encrypted copies of images by post. We were concerned that multiple methods of information transfer could increase the risk of information loss, or breach of confidentiality. However, staff told us there had not been any information governance breaches.

Medicines

- The service did not stock, administer or prescribe any medicines (including emergency medicines) and did not use contrast mediums for their investigations.

Incidents

- Staff were able to report incidents online and could print a copy of the submission which included a note of actions taken. However, there was no process in place to easily retrieve incidents or generate a report of incidents, to enable proper oversight, of incidents reported by clinic staff.
- The team had started to keep a paper copy of any incidents they reported in a team folder so they could be easily retrieved and referred to for shared learning.
- We saw evidence of shared learning from an incident with a research subject (not a YDI patient) and actions taken following a recent incident. The incident had been discussed in team meetings and we saw that actions had led to the addition of a metal detector to the patient safety procedures. Any relevant incidents would be reported to the Health and Safety Executive in line with regulatory requirements.
- However, we only saw evidence of one incident reported in the last 12 months which may mean the service is under-reporting incidents. For example, we heard that a query had been raised by a referring professional about missing information on a scan report. Although the query was fed back to the reporting company and there was no patient harm (the omission did not affect the patient diagnosis or treatment) the report was amended to include some other information. We felt that this should have been reported as an incident even though there was no harm to the patient.
- There was an incident and complaints policy for YDI and an overarching accident investigation policy for the University of York. Although the YDI policy gave definitions and examples of different types of incidents / accidents this was limited and potentially led to under-reporting for occurrences that would not necessarily have led to patient harm. For example, it was unclear whether things such as reporting errors or omissions, lost or delayed results, wrong part scan or information governance breaches such as reports not received or sent to the wrong address would be recognised as needing reporting. The incident and complaint policy gave guidance regarding duty off candour and staff told us they would immediately let a patient know if anything had gone wrong, however they had not had to do this.

Are outpatients and diagnostic imaging services effective?

We do not rate the effectiveness of diagnostic imaging services, however, we found the following during our inspection.

Evidence-based care and treatment

- The provider had developed local rules regarding MRI scanning and there was a full document history on the cover sheet. These were to be reviewed every three years and were in date. The local rules were very comprehensive and in line with practice guidance.
- The local rules for MRI were based on the MHRA guideline: DB2007(03) 'Safety guidelines for Magnetic Resonance Imaging Equipment in Clinical Use' which was printed and available for staff reference.
- There were also several protocols regarding routine scan sequences and referral specific scans, which the

radiographer told us they had updated recently after joining the service, however, there was no date of writing or review date and these documents were not referenced. However, Royal College of Radiologists (RCR) guidelines and other reference materials had been printed and were available for staff to refer to.

- Protocols for each scan sequence and local rules were readily available in the unit.
- The service director told us that all unit policies had recently been reviewed and staff had been given the opportunity to contribute to any changes. Following revision, staff were given reading time to bring them up to date with the changes made.

Nutrition and hydration

- Patients were able to access hot and cold drinks while waiting for their scan.
- Reception staff told patients drinks were available if they would like one.

Pain relief

- Staff demonstrated they were aware that patients may be in pain and they ensured the scan caused as little discomfort as possible. Positioning aids were available if needed and staff checked on patients' comfort via the intercom during the scan sequences.
- Staff gave an indication of the time the scan would take and checked that patients would be able to remain comfortable and still during the examination. Patients could alert staff if they were uncomfortable and needed the scan to stop. We saw staff shorten the time of the scan for one patient who was very uncomfortable.
- We were unclear if patients were assessed or advised about taking pain relieving medicine before attending their appointment if this was likely to cause discomfort. The clinic did not use any pain assessment tool during scanning procedures.

Patient outcomes

- We heard patients being given verbal instructions before leaving the clinic to let them know when their scans would be reported and when they could expect them to be back with the referring clinician.
- Staff told us that scan reports would be expected back into the clinic within 48 hours and they would have sent the report and a copy of the images the day after receipt.
- Staff told us there were no issues receiving reports back in 48 hours. If reports were not received as expected staff told us they contacted the reporting company at once and reports were always made available as soon as possible. The reporting company provided YDI with quarterly reports which showed that the average reporting time was 30 hours. YDI was able to return reports to referrers within seven working days for 85% of patients.
- There was a quality assurance mechanism in place through the service level agreement with the radiology reporting company and the company provided YDI with an annual performance report. The annual report included results from internal and external audits of YDI reports from prospective and retrospective peer reviews. From January 2017 to December 2017, 93.8% of peer reviewed reports had full agreement or contained only a minor disagreement, one report (6.3%) had a moderate disagreement and 81% of reports were within the turnaround target of two business days.
- The external audit from January 2018 to June 2018, showed that the reporting company achieved 100% for the three indicators of; accuracy, clinical and language. The internal audit for the same period showed that in 100% of cases 'no clinically relevant modifications' were required.
- From August 2017 to July 2018 100% of scans were reported on within five working days.
- The radiographer told us they had the scope to adjust protocols to improve optimisation or take additional images if they were unhappy with the quality of imaging. Staff said they would do this rather than risk the patient having to return for a further scan. Although it had never happened the staff told us if the reporting company expressed that images were not clear they would ask patients to return and be rescanned at no extra cost.
- The service did not undertake any audits themselves regarding image reporting or patient outcome indicators such as appropriateness of referrals. They

felt that if there were any queries or issues regarding the reports then they would hear about these from the referring professional. The staff could only remember a query being raised on one occasion during the last 12 months and the issue had been dealt with immediately upon contacting the reporting company.

Competent staff

- Staff had received training relevant to their role. We saw online training records that showed the required training and level of competence of different members of staff. Each staff member's role and operator level was clearly recorded on the system.
- MRI scanning was always undertaken by a qualified radiographer with expertise in MRI scanning. Agency radiographers were given an induction and training regarding the unit, policies and procedures and safe use of the MRI scanner. The manager of imaging services also worked alongside the agency staff for a number of shifts for support and supervision purposes.
- The radiographer, support and research staff were all trained in MRI safety. Staff were trained at MRI operator level 0,1,2 & 3 depending on the relevance to their role.
- One of the assistants told us they had received an induction to the unit which had included MRI safety and had received level zero training in the use of the scanner. The staff member told us they would receive further training as their placement progressed.
- We saw that individual members of staff received an email, triggered from the system, if any of their required training was due for renewal and that the clinic director also received a copy of the reminder. The clinic director told us that there was a month's warning period for training renewal.
- The online system highlighted any staff that were overdue for any aspect of training and 'suspended competence'.
- We found that there was a structured probationary period for new staff and for all staff there were ongoing annual appraisals and mid-year performance reviews. New staff received an induction and three, six and nine-month reviews. We looked at the records for two members of staff and found that reviews and appraisals had been undertaken and staff had clear objectives regarding performance and development for the coming year.
- Data provided by YDI showed that 100% of staff employed for more than 12 months had received an annual appraisal in the last 12 months. The service had checked the professional registration status of their radiographer.
- Staff told us that training and development was supported, this ensured competence was maintained and registered professionals met re-validation / re-registration requirements.
- Reception staff were included in training which meant they had the relevant safety knowledge and understanding to enter the controlled areas if needed, for example to act as a chaperone.

Multidisciplinary working

- We saw that the team included, managers, a radiographer, administration staff and support / research workers who all worked well together to provide a cohesive service to their patients. Staff had a good understanding of each other's' roles and felt that this contributed to improved teamwork and shared learning.
- Members of the team communicated well with each other and gave examples of when they had liaised with referring clinicians and or the reporting company / consultants to address any queries or to provide or obtain any necessary information regarding the patient's pathway.
- The service encouraged feedback and was open to feedback from reporting radiologists and referrers to ensure information and images provided were of a good quality and the service was effective for patients and meets the needs of the referrers.

Seven-day services

- The clinic had recently changed from an ad hoc appointments system spread across the week to a dedicated clinic held one day a week on a Monday between the hours of 11.30AM and 6.30PM.

- Staff told us that if a patient could not attend on a Monday then they could arrange an appointment at another time if necessary.

Health promotion

- There was no health promotion information on display in the waiting or clinical areas.

Consent and Mental Capacity Act

- Staff we spoke with had a basic understanding of mental capacity and informed consent and patients were given enough information to consent to the MRI scan. Staff had limited experience of scanning patients who may be confused or lack capacity as patients with these problems were not usually referred to the service. Staff told us they would not go ahead with a scan if a patient refused or was unable to consent. The policy stated that the refusal would be documented and the referral returned to the appropriate clinician.
- There was a process in place which combined MRI safety and consent for patients. This ensured patients were informed of the risks of MRI and were checked to ensure there were no contraindications for the scan going ahead. When the patient attended for their scan they were asked to complete and sign the 'MRI Safety Questionnaire and Consent for Patients' by receptionist staff. The HCPC registered radiographer later asked the patient to confirm verbally their answers to the 'MRI Safety Questionnaire and Consent for Patients' and countersigned the form if the patient was safe to be scanned.
- The consent policy gave guidance regarding adults that lack capacity and consent and children, however the policy stated that "Where an adult is considered to lack capacity under the Mental Capacity Act 2005 and is unable to provide consent, the decision to undergo examination or treatment can be made by the clinician or family." This is incorrect - a family member cannot consent on behalf of another family member. The policy gave appropriate advice regarding the consent of children and stated that "if a child does not submit freely to the examination then the examination will not be performed regardless of whether or not consent has been given by their parent or guardian." However, the policy was unclear regarding 'parental responsibility' as it stated that a responsible person known to the child could accompany them. This needed to be clear that the person accompanying the child needed to be a person with 'parental responsibility'. A person without parental responsibility cannot give consent on behalf of a child.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as **good.**

Compassionate care

- We observed that all staff were polite and courteous to patients from arriving at the department to when they left.
- Patients were shown to changing cubicles to maintain privacy and dignity while changing for scans. Staff gave patients a box for their personal belongings and these were placed in individual lockers while the patient went into the scan room.
- Staff escorted patients from one area to another and treated patients with dignity and respect.
- We observed staff communicating with patients through the intercom to ensure patients were as comfortable as possible during the procedure. We saw the radiographer adjusting their approach and reducing the length of the procedure for one patient who was very uncomfortable.
- Patients told us they were happy with the service and that they had been talked through what to expect at every stage of the process.
- We observed staff maintaining privacy for patients by shutting doors when answering questions.
- There was a 70% return rate from patient feedback forms and over 90% of the respondents rated the overall service as excellent. We saw that patient feedback was taken seriously and actions were taken as a result.
- We saw that staff considered the needs of patients and as an example we saw that staff had discussed and were intending to develop a best practice document

regarding chaperoning. Clinic policy was that where a patient requires a chaperone for any reason, staff would endeavour to accommodate the request as long as safety is not compromised.

- There was no female member of staff on duty in the clinical area during our inspection who could act as a 'female chaperone' if asked. However, information provided by the service indicated that receptionists may act as chaperones but it was unclear whether they had received training to fulfil this role.
- All staff had received customer care training.

Emotional support

- Staff gave examples of how they supported patients within the scan room for example when patients may be nervous about the scan procedure or anxious due to the confined space of the scanner itself.
- Staff told us they would stay in the room with the patient where they could be seen if necessary and told us they had done this on a number of occasions with patients who were extremely anxious or claustrophobic.
- Staff told us it was common for patients to feel anxious or claustrophobic in the scanning area but that they usually managed to keep patients calm and able to complete the procedure by talking to them through the intercom, or by staying in the room and being visible if necessary.

Understanding and involvement of patients and those close to them

- We saw staff going through safety checklists and contraindications with patients to ensure they understood what was to happen and that they were aware of any risks to safety.
- Patients were given the opportunity to ask questions or to tell staff if there was anything they did not understand.
- Patients told us staff had explained safety precautions and that they understood possible issues and the reasons why they had to remove jewellery, piercings etc.
- Staff explained what was happening by communicating throughout the scan.
- We saw staff ensuring patients understood when their results would be back with the referring health professional.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

- The clinic provided car parking spaces for service users next to the building.
- The waiting area had comfortable seating for six patients and the clinic was accessible to users of wheelchairs.
- Patients were provided with adequate information about their scan and when their results would be available.

Meeting people's individual needs

- The service was accessible to patients with a disability. There was a door bell if patients needed help to access the front door as it wasn't automatic. Toilets were accessible and call bells reached the floor in case of a fall.
- There was a TV in the waiting area switched to the news channel and some magazines to distract patients while waiting for their scan.
- There was little room in the waiting area for a wheelchair but generally the unit was spacious and chairs could be moved if necessary.
- There was little in the way of displays, toys, or materials for children to keep them distracted if they had to wait for a scan. Staff told us they would change to a children's TV channel when there were children in the department.
- The service had found a photo story they could direct parents to, for young children to look at before visiting the unit. 'Jack's MRI Scan' describes an MRI scan from the perspective of a child and was suitable for children up to 10 years.

Good

Diagnostic imaging

- The service was able to provide information in braille if needed but was dependant on referrers identifying additional needs so they could respond appropriately.
- Patients could be accompanied in scanner room if needs indicated this was necessary. This could be by a member of staff or the parent of a child as necessary.
- Patients could listen to music or watch a video when they were in the scanner.
- The service had policies in place to respond to patients with mental health or sensory problems, however service users had not fallen into those categories over the previous 12 months. The service had not scanned anyone lacking capacity but this was to be expected as the patient group were generally self-paying adults who were able to access the service independently (via a referrer).
- Although staff told us they had never had to turn a patient away, there was no explicit referral or acceptance criteria for the service for example. It was unclear if the equipment available would restrict access to the service. For example, maximum size or weight that the scanner could take was not stipulated, nor was a level of mobility required however the service did not have a hoist or other manual handling aids to assist patients on and off the scan table.
- Staff told us they had not yet had to scan a patient who did not speak English and that they would need to consider how best to provide translation if the need arose. They felt that this would be highlighted at booking by the referrer and this would give them the opportunity to arrange an interpreter if needed before the patient came for their appointment.
- There was guidance for staff in the use of interpreters who were a relative or friend of the patient. If staff were in doubt about an unreasonable breach of confidentiality, the appropriateness of translation or if they felt the patient could not respond without inhibition then they were to defer the examination until a proper interpreter could be provided. However, this is not in line with best practice which would be to ensure an independent interpreter was made available if needed.

Access and flow

- The service director told us that the clinic carried out approximately 350 scans a year. The majority of scans undertaken were for MSK complaints and there were a small number of brain scans undertaken each year. There had been 69 patients scanned in the latest quarterly service review.
- Patients were all self-funded and were referred by their GP or an AHP such as a physiotherapist or osteopath / chiropractor.
- The service received referrals by email and fax from approved referrers. On receipt of the referral the receptionist telephoned the patient to arrange a convenient date / time for an appointment. Appointments were usually for the following Monday clinic. One of the patients told us they had waited longer than this but that it had been their choice.
- The majority of the patients accessing the service since August 2014 were between 16 and 65 years (77%), 21% of scans were for people over 65 years and less than 2% were for children under 16 years.
- Staff told us that the Monday clinic had between six and 12 patients. Patients were given a 30-minute time slot and that this was usually plenty of time. Staff told us that if a scan took longer than usual and this meant the next patients would be scanned late they would inform the patients of the delay and give an apology. Staff told us patients were usually seen on time and it was rare for patients to have to wait more than a few minutes past their appointment time.
- The service had measured the impact of changing their delivery model to a once weekly clinic as they had anticipated this may have an adverse effect on referral to scan time. However, the service had found this did not happen but rather the percentage of patients receiving their scan within five working days had improved from 77% to 80% and the percentage of patients accessing a same day scan had risen from 26% to 32%.
- From August 2017 to July 2018 78% of patients received their scan within five working days of referral.
- Patients told us that the service was 'super easy' to access, they had only waited a week for their

appointment and they found the unit easy to find. They had been given clear instructions / directions when the receptionist had telephoned them to arrange their appointment.

- We observed that patients received their scans on time or a few minutes early. Patients were given plenty of time to change and for their scan and were not rushed.
- Scan results were expected to be returned from the reporting company within 48 hours and the service ensured they transferred these on to the referrer by the following day. That meant patients scanned on a Monday would be able to discuss their results with their referrer on the Thursday or Friday of the same week.
- Pricing of scans was visible to patients on the service website.
- There were no capacity or waiting list issues and there had been no cancellations by clinic staff for any reason. Four appointments had been rearranged or postponed due to patient requirements/ requests.
- The service had planned closures at Christmas and Easter and the facility had a maintenance closure for two weeks in the Summer. However, this had reportedly not impacted on patient waiting times.

Learning from complaints and concerns

- There was a complaints and incident policy which included a second stage process. If a response to a complaint did not meet the needs of the complainant, the University Registrar and Secretary could be contacted to take the issue further.
- The complaints procedure was available on the YDI website allowing patients and referrers to access the appropriate information governing complaints. People could also raise concerns or complain in the free text areas of the patient satisfaction questionnaire, given to all patients.
- Patient feedback was collected through comments cards and anything highlighting as an area for improvement was actioned. For example, patient feedback regarding difficulty finding the clinic had led to the service reviewing the documentation sent to patients to enable them to get to the premises by private and public transport.
- Patients used a 'post box' in the reception area to return their feedback anonymously.
- Staff told us they had never had any formal complaints but if a patient raised any issues or difficulties with them they would deal with the concern at once.
- The University of York had a whistle blower policy available to YDI staff if they felt unable to raise issues with members of staff within the immediate team providing the service.
- The service received 27 written compliments from July 2017 to August 2018.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as **good.**

Leadership

- The service was led by the director who was the registered manager for the service and was supported by a manager of imaging services who was responsible for the day to day running of the unit. The scanning lead was a HCPC registered radiographer.
- The director reported to the University of York Head of Department of Psychology with formal reports to a management board (three times per year) that had representation from senior management within in the University of York
- We saw there were twice weekly meetings for the clinic staff and leaders were present at these meetings. Minutes of meetings and the action log indicated an inclusive approach to the running of the unit and the delivery of the service.
- The twice weekly team meetings were; one with an agenda and minutes and the second as a catch up to review progress against an action log and to set the agenda for the following week. We saw minutes and

the action log that indicated incidents, patient feedback, changes to service delivery, or any other issues that needed addressing were discussed in this meeting. Staff felt these meetings were valuable for team work, to enable staff to contribute their ideas, to discuss training needs and to ensure smooth running of the service. An example of a positive outcome for all staff from these meetings was that all clinic staff attended customer service training the previous summer.

- Staff said they felt supported and that the leaders were approachable, they gave examples of being supported with training and development and told us that their ideas were listened to and acted upon in discussion with the team.

Vision and strategy

- Senior staff could clearly articulate their vision for the service and the director was in the process of writing a new strategy for the service, as the existing strategy was out of date. The draft strategy covered the period 2018 to 2020 and included a mission statement and self-assessment regarding how far the service met the vision it aspired to. There was a number of action points for improving the quality and delivery of the service and estimated timescales. The strategy was due to be submitted to the York Neuro Imaging Centre (YNiC) management board for consideration and approval at the next meeting planned for November 2018. Although there had been period of a number of years without a formal strategy it was evident the service had taken action to develop and improve the service during this period.
- The director told us feedback from users of the service had been taken into account as had staff views when developing the strategy.
- During a customer service event in 2017 the staff had identified that their objective was to 'deliver the best in diagnostic imaging'. It was evident from conversations with staff and from records of staff meetings that staff were engaged with this ethos and worked towards improving the service to make it more resilient and to improve the experience of patients.

Culture

- There appeared to be an open culture where there was an emphasis on collaborative working, a desire to continuously improve and shared learning.
- Policies and procedures were in place to guide staff practice and expected behaviours. Policies indicated that any issues, where staff acted outside of policy or displayed inappropriate behaviours, would be taken seriously and dealt with appropriately.
- Although staff were unable to give examples of occasions when they had to raise concerns about staff practice issues this responsibility was clear in the YDI code of conduct policy. There was a whistle-blowing policy to support staff with this course of action if this became necessary.
- Staff told us they felt listened to, supported and that training and development was encouraged.

Governance

- YDI was managed under the University of York governance model 2 which meant that it was not fully autonomous from the directorate of psychology. This meant the unit benefitted from the support and help of the directorate as a whole. For example, it meant the unit was more sustainable and was supported by the administration, health and safety, HR, and finance functions of the university.
- There was a clear governance structure where the director of the service held a quarterly review meeting to discuss service performance. The outcomes of the meeting were shared with all staff at the weekly staff meetings.
- The director was also required to report formally to a management board that met three times a year and was chaired by the head of department of psychology. The management board had a broad membership reflecting senior management of the university; research, teaching faculty members, finance, business and human resources staff. The management board had oversight of all the activity at the site including the diagnostic imaging service. The director's reports included; how the facility was performing and what issues and challenges it faced. We saw that health and safety; finance and sustainability, patient feedback and activity were standard agenda items and there

was a solution focussed approach to any issues raised. There was an annual planning process in place and any business development proposals would also be taken to these meetings for discussion and approval.

- The director received quarterly performance reports from the reporting service and told us they had a good open relationship with this provider which enabled them to deal with issues when they arose. Staff told us issues were infrequent and would typically be concerning delays in reporting or issues in uploading data.
- There were good systems and processes in place for maintenance of equipment and there were appropriate policies, local rules and protocols in place. However, a number of policies had some omissions or needed updating in line with current guidance.
- There was oversight of staff training, competence and that relevant staff had current professional registration although relevant training information was held in a number of places which made this more difficult than it needed to be.
- There was a system in place to ensure that referrers were approved and were registered health professionals.
- Although we saw good shared learning from a recent incident we were concerned there may be under-reporting of incidents which meant there were missed opportunities for learning and improvement.

Managing risks, issues and performance

- The service had systems and processes in place to minimise risks and manage issues and performance. There were unit specific risks identified which had been considered in terms of likelihood and impact. There were appropriate mitigations in place.
- The risks for the unit were included on the risk register for the department of psychology which in turn fed into the risk register for the University of York.
- The service had indemnity and insurance in place.

Managing information

- All staff had undergone information governance training and we saw that the recent changes to General Data Protection Regulation **(**GDPR) had been considered and discussed at a staff meeting. The unit's GDPR self-assessment was compliant all six areas.
- The service was registered with the Information Commissioner's Office and the director was the Caldicott guardian for the clinic.
- There were systems and processes in place to maintain security of information including patient records. There were minimal paper records for patients and these were scanned on to an electronic system for retention and destroyed at the end of an episode of care.
- We had a concern that YDI used multiple methods of information transfer, which mirrored the referrers choice of communication method as this increased the risk of information loss, or breach of confidentiality. However, despite the lack of a consistent method of information transfer or delivery, the staff told us there had not been any information governance breaches.

Engagement

- Staff were engaged in the delivery and improvement of the service through twice weekly team meetings which gave them the opportunity to be involved, give ideas and hear praise and positive feedback from managers and service users.
- Patient engagement was ongoing through the use of comments cards and response rate was very good at around 70%. Over 90% of the respondents rated the overall service as excellent. We saw that patient feedback was taken seriously and actions were taken as a result. For example, information given to patients had been improved regarding finding the unit as some patients had not found this easy.
- Staff told us that they had previously asked referrers for feedback on the service through annual surveys but the response had been poor. They had decided to change their engagement approach with referrers to topical communications and requests for opinions. At the time of the inspection there was a survey ongoing regarding the provision of compact disc (CD) copies of

images. The service felt this was no longer necessary as images were usually transferred electronically but did not wish to cease the practice without first gaining the opinion of their referrers.

Learning, continuous improvement and innovation

- We saw that managers and staff valued learning and wanted to continually improve their service. We saw that learning was shared and staff had opportunities to contribute to service development.
- Professional and role development was encouraged and supported and we saw that staff reflected on training in a way which led to improvements in patient care / experience.
- We saw that leaders were looking for opportunities to develop / expand the patient service and were open to suggestions from patients and stakeholders. The service was keen to learn from others and fostered good relationships with its service users and suppliers.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to meet the regulations:

- The provider must ensure that the records management policy and consent and safeguarding policies are reviewed in line with current best practice guidance and have any incorrect information removed or amended to ensure guidance complies with current legislation and best practice.

Action the provider SHOULD take to improve

- The provider should consider how incidents are recognised and reported to ensure there are no lost opportunities for learning and improvement.
- The provider should consider developing a programme of audit to monitor compliance with policies and protocols and to monitor outcome such as image quality and appropriateness of referrals.
- The provider should ensure that the new process to check the grab bag equipment and the defibrillator checks and self-test are embedded and carried out on a regular basis.
- The provider should ensure policies and protocols are referenced and include writing and review by dates.
- The provider should consider what health promotion information would be suitable for its patients and could be reasonably made available.
- The provider should consider if any improvements can be made regarding managing patients discomfort or pain during scanning.
- The provider should consider how it could make its environment friendlier for children attending the unit and how they would meet the needs of patients who could not speak English.
- The provider should consider its methods of receiving and transferring patient information to and from referrers to improve consistency and reduce any risk of information loss or breach of confidentiality.
- The provider should consider whether it would be appropriate to develop acceptance / exclusion criteria for referrals based upon any limitations of the service / equipment.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance