

Imaging Services

Walsall Healthcare NHS Trust

Visit Date: 13th March 2018

Report Date: June 2018

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INTRODUCTION

This report presents the findings of the review of Imaging services at Walsall Healthcare NHS Trust that took place on the 13th March 2018. The purpose of the visit was to review compliance with the following West Midlands Quality Review Service (WMQRS) Quality Standards:

- WMQRS Quality Standards for Imaging Services, Version 1.2, December 2013

The aim of the standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The report also gives external assurance of the care which can be used as part of an organisations' Annual Governance Statement (AGS). For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where developments may be needed.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. **Appendix 1** lists the visiting team that reviewed the services. **Appendix 2** contains the details of compliance with each of the standards and the percentage of standards met.

This report describes services provided or commissioned by the following organisations:

- Walsall Healthcare NHS Trust
- NHS Walsall Clinical Commissioning Group

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches; some require commissioner input. Individual organisations are responsible for taking action and monitoring this through their usual governance mechanisms. The lead commissioner for the service concerned is responsible for ensuring action plans are in place and monitoring their implementation liaising, as appropriate, with other commissioners, including commissioners of primary care. The lead commissioner in relation to this report is Walsall Clinical Commissioning Group.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS is a collaborative venture between NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews – often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are: better quality, safety and clinical outcomes; improved patient and carer experience; organisations with more robust information about the quality of clinical services, and organisations with more confidence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on www.wmQRS.nhs.uk.

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and service users and carers for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit.

Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

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IMAGING SERVICES

WALSALL HEALTHCARE NHS TRUST

General Comments and Achievements

Reviewers noted that there was a highly motivated team in place, with good staff morale. Members of the team were loyal to the service and enthusiastic in their role. Staff felt supported when raising concerns and this was evidenced when they referred 'inappropriate' referrals back to GPs avoiding unnecessary journeys for patients.

Reviewers saw that there was a positive working environment, people wanted to work at the Trust and were happy to stay there. Good team working was evident.

Reviewers saw evidence of good leadership although reviewers did feel that the senior management reporting lines were not clear and therefore felt that there could be a lack of clarity for other staff members in the team.

Reviewers did note that there was a lack of clear and accessible patient information and that patient feedback was limited, resulting in a lack of patient involvement in development of the service.

Overall, we saw a good service, with evidence of good practice, though some concerns and one immediate risk were identified. More detail is outlined as follows:

Good Practice

1. There was a very comprehensive induction pack in place for all new starters, supported by a robust checklist for agency and locum staff. Staff therefore knew exactly what they had to do and how the service worked.
2. There were excellent training, education and personal development processes in place, achieved primarily by the leadership and example of the training and education lead. Mandatory training compliance was high, and this had been achieved largely by the education lead providing robust planning and targeted cover for those struggling to be released from their roles. However, reviewers noted that some training compliance documentation was incomplete for example not all records were signed and dated.
3. Reviewers felt that the 'three armed' gown (a wraparound garment which provides additional privacy for patients) was effective for improving patient privacy and dignity. Reviewers saw this in use with no problems but felt some guidance on how to use / wear them might be useful.
4. Some examination rooms had been decorated to be dementia friendly which was seen as good for patients living with cognitive impairment and dementia; this reduces anxiety in unfamiliar environments.
5. Acclimatisation visits for patients with learning disabilities were offered, which were led by the Assistant Practitioner. Reviewers heard that one patient had six visits until they became comfortable and the service told us they were keen not to rush patients which reviewers saw as a good example of responsive patient care.
6. Emergency Department (ED) plain film reporting cover over the weekend was available. This reduced the backlog for Monday mornings and ensured images taken at the weekend were reviewed as soon as possible by an appropriately qualified practitioner. (Although see the Immediate Risk section later regarding impact on radiologist workload).
7. Reviewers saw a robust process for vetting of Computerised Tomography (CT) referrals to ensure they were appropriate; which reviewers identified as good practice.
8. The weekly staff huddle was viewed as an effective method of cascading information and learning down to the rest of the teams.
9. The service followed the Royal College of Radiologists (RCR) WHO audit checklist for interventional procedures. Reviewers saw high levels of compliance with the checklist.

10. A checklist was used in CT to ensure a consistent process was always followed. The checklist was also reviewed and considered as an example of good practice by the review team
11. The update sheet for IR(ME)R refresher training was a positive example of ensuring staff maintained up to date core competencies. Reviewers were impressed that the same record also included radiologists and was truly multidisciplinary.
12. Centralisation of advanced practice reporting radiographers had led to a marked increase in reporting productivity due to the ability to cover each other. It had also improved team morale and provided the environment that allowed staff in this team to support each other. These improvements had been helped by the team being situated close to the Radiologists' reporting rooms.

Immediate Risks

1 Radiologist workload.

Reviewers saw that Radiologists workload was unsustainable.

- a. Reviewers were told that the National RCR benchmarking (RCR Clinical Radiology UK Workforce Census 2016 – published in Oct 2017) identified Walsall as the worst hospital in the country for examinations per Radiologists. Trust specific data were not nationally published; but reviewers were made aware of the local data during the review which evidenced the issue.
- b. There was a shortfall in the required number of radiologists. Following national Royal College guidelines, the service should have 20 Radiologists to meet the national average number of radiologists in post, whereas there are only 8 radiologists in the department. There is a risk that this could lead to a loss of specialism amongst radiologists who are trying to cover multiple areas and specialities.
- c. There was a minimal backlog of reports, which is commendable. However, achieving this with the current workforce constraints is a further indication of the high workload of radiologists. Reviewers felt that it is not possible to maintain this level of reporting with the current compliment of staff, without significant overworking or impacting on the quality of reporting. This means that there is a high risk of burnout amongst Radiologists.

Reviewers were concerned that given the efforts made by Radiologists to cover the clinical activity and lack of reporting backlog (driven by a highly motivated desire to provide the best patient care); the Trust may not be fully sighted on the risks to staff and patient care.

The Trust has confirmed that an additional locum has been appointed and that a workforce review will be completed including the development of a Business Case for Executive consideration regarding the capacity gap.

Serious Concern

1 Infection Prevention Control.

Reviewers were concerned by some of the Infection Prevention Control (IPC) practices they observed.

- a. Some staff were observed wearing large items of jewellery; other staff were observed with long hair which was not tied back; and some members of staff were wearing non-wipeable footwear.
- b. Reviewers observed little handwashing by some staff as they moved between patients
- c. Reviewers noted that staff were not wearing gloves when loading an injector pump.

Reviewers concluded that due to the number of instances observed, that they were concerned that robust IPC practices were not fully understood or embedded across the whole team. This was confirmed by the recent IPC audits undertaken within the department.

The Trust has confirmed that communications have been issued to staff reinforcing IPC messages and the importance of hand washing. Team leaders have been reminded to be vigilant in monitoring compliance with the IPC policy.

Concerns

1. There was no capital equipment replacement programme. Some pieces of equipment are at the end of their working life. Beyond the replacement for the CT scanner; there does not appear to be an agreed programme for capital replacement, especially for high cost equipment. Reviewers were concerned that there appeared to be minimal ownership of the plan or its development from radiology. Reviewers were told this was the responsibility of Electro-Biomedical Engineering department (EBME). Reviewers considered that the radiology service should be driving the equipment replacement programme within the Trust. Reviewers were uncertain on how the Trust was gaining assurance on image quality and clinical functionality for equipment at the end of its working life that was still being used for clinical diagnostic purposes. Reviewers would suggest the team should seek assurance on image quality of the existing older equipment.
2. The radiology service is considering introducing a new radiographer career progression framework. Although the plan is still in development, reviewers heard that the plans being considered could mean that new staff would have the opportunity for automatic progression from Band 5 to Band 6 within two years if appropriate competencies are developed. However, reviewers cautioned that there was a need to ensure existing staff also have a plan for progression in a similar manner to maintain the stability and morale in the service, which they were advised was under consideration.
3. Reviewers heard that sonographer staffing levels were below nationally recommended levels although reviewers noted that this remains a national problem and is not local to Walsall.
4. There was no single written operational policy for the service. Reviewers were concerned that there was a lack of clarity for all members of staff which will inevitably result in inconsistencies.
5. The QA programme on lead coats was not up to date. Reviewers were told that in main theatres this was last completed in 2016. Other lead coats in the department were overdue for their QA on these important protective barriers for staff.
6. Reviewers saw that version control of documentation was not consistent which may result in different versions or out of date versions of documents being in clinical use.
7. Reviewers noted that a second check on IV pumps for correct contrast was not routinely undertaken. Reviewers felt that this should be considered by the Trust and reflected in the appropriate policy.
8. Reviewers noted that there appeared to be a general lack of engagement with patients in development of the service. Reviewers could not see, and staff were unable to describe, a process where patients views, and input was considered as part of the ongoing continuous service improvement and development.
9. The reviewers felt that there were some privacy and dignity considerations with ward patients coming down in night clothes and waiting in the same area as outpatients in their own day clothes without the opportunity to be offered some privacy screening. Reviewers noted that on the day of the visit, one CT scanner was broken, and it is possible that this may have led to congestion in the waiting area appearing worse than usual. Patients in their bed can often feel more vulnerable and exposed in these circumstances.

Further Consideration

1. Reviewers saw patient information written in different styles and often in very 'technical' language. There were no issue dates or documentation control. Reviewers felt that the team would benefit from working with patients on this to help them in developing the literature.
2. Reviewers were only able to see patient documentation in English and not in other languages. Reviewers did not have the opportunity to explore this further and the service will want to assure itself that an appropriate provision is made.

3. Reviewers noted that the radiation 'Controlled Area' lights should be checked to ensure that they meet requirements of IR99, as not all have been moved over to the new design.
4. RCR discrepancy meetings were held. However, Reviewers were not sure that the latest guidance from the RCR (published in Oct 2014) was being followed. This would further improve the quality of these meetings.
5. Reviewers would suggest the service looks at the consent process for invasive procedures. It appeared to reviewers that patients receive an information leaflet with details in the post; but formal consent is only taken on the day of the procedure. Reviewers were unable to ascertain if consent and discussion with patients was also being undertaken by the referring clinician. The service should assure itself that the consent policy and process comply with national guidance and that best practice was being followed in obtaining truly informed consent.
6. Reviewers noted that in some areas, records of storage for medication that is temperature sensitive are not always maintained and acted upon. Reviewers were aware that contrast was stored in some rooms without awareness of the room temperature. The Trust should review protocols and practice to ensure that this is not common practice and that staff are reminded of the need to monitor storage temperatures.
7. Reviewers observed that the transvaginal probe was decontaminated using a wipe. Whilst the Trust has confirmed that this meets current MDA/2012/038 and manufacturers guidance, reviewers highlighted that new guidance in Scotland and Ireland, which requires a higher standard of decontamination, is available and the Trust may wish to consider the recommendations which this guidance provides.
8. The 'Hover mat' was useful for moving and handling patients during transfer between their bed/trolley and examination couch and was seen as extremely useful by staff. However, staff told us they relied on it regularly being available and had concerns that it may be removed for use by other departments and wards in the Trust. The Trust should consider ensuring that this is permanently available in the department.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team		
Jenny Cooke	Advanced Practitioner Radiographer	Burton Hospitals NHS Foundation Trust
Nick Flint	User Representative	
Debbie Jones	Support Service Care Group Director	The Shrewsbury and Telford Hospital NHS Trust
Emma Land	Deputy Superintendent Radiographer	Worcestershire Acute Hospitals NHS Trust
Stuart Simper	Group Manager Radiology	The Royal Wolverhampton NHS Trust
Dr Umesh Udeshi	Consultant Radiologist / Director of Radiology	Worcestershire Acute Hospitals NHS Trust

WMQRS Team		
Tim Cooper	Director	West Midlands Quality Review Service
Rachael Blackburn	Assistant Director	West Midlands Quality Review Service
Sarah Broomhead	Assistant Director	West Midlands Quality Review Service

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APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varies depending on the nature of the service provided. Percentage compliance also takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No, but', where there is real commitment to achieving a particular standard, than a 'Yes, but' where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, table 1 summarises the percentage compliance for each of the services reviewed.

Table 1 - Percentage of Quality Standards met

Details of compliance with individual Quality Standards can be found below.

Service	Number of Applicable QS	Number of QS Met	% met
Turst Wide	1	0	0
Imaging Services	49	34	69
Total	50	34	68

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ACUTE TRUST-WIDE

Ref	Standard	Met Y/N	Reviewer Comments					
XC-505 <table border="1"> <tr><td>BI</td></tr> <tr><td>Visit</td></tr> <tr><td>MP&S</td></tr> <tr><td>CNR</td></tr> <tr><td>Doc</td></tr> </table>	BI	Visit	MP&S	CNR	Doc	Ultrasound Guidelines Trust-wide guidelines for the governance of ultrasound should be in use covering at least: <ol style="list-style-type: none"> a. Identification of ultrasound equipment, maintenance arrangements and PACS connectivity b. Arrangements for ensuring all ultrasound practitioners have appropriate competences, their frequency of ultrasound practice is sufficient to maintain these competences and for audit of their practice c. Arrangements for delegation to non-medical ultrasound practitioners d. Arrangements for supervision of doctors in training undertaking ultrasound e. Guidelines on cleaning ultrasound probes f. Arrangements for recording and storing images and ensuring availability of images for subsequent review g. Arrangements for documentation and communication of ultrasound results 	N	Trust-wide guidelines were not accessible to reviewers at the time of the visit.
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IMAGING SERVICES

Ref	Standard	Met Y/N	Reviewer Comments
XR-101 BI Visit MP&S CNR Doc	Imaging Service Information Patients should be offered written information about: <ol style="list-style-type: none"> Imaging services provided, location and hours of opening How to contact the service Staff they are likely to meet Informing staff if they are, or may be, pregnant or breastfeeding Radiation risks, including information for women who are, or may be, pregnant or breastfeeding 	N	Leaflets reviewed were not patient friendly and were very 'technical' and therefore information was not accessible. Some information was also out of date and there was a lack of document control.
XR-102 BI Visit MP&S CNR Doc	Procedure Information For each imaging procedure, patients should be offered written information, and the opportunity to discuss this, covering: <ol style="list-style-type: none"> Preparation for the procedure Staff who will be present at or who will perform the procedure Any side effects How, when and by whom results will be communicated 	N	As Quality Standard XR-101
XR-103 BI Visit MP&S CNR Doc	Privacy, Dignity and Security Patients' privacy, dignity and security should be maintained at all times, including security of clothes and personal belongings during examinations and procedures.	Y	However, see further considerations above. Reviewers did note that inpatients were arriving in the department in night clothes whilst outpatients were in their day clothes. Reviewers did note that this could have been because one CT scanner was broken and it is possible that this may have led to congestion in the waiting area appearing worse than usual
XR-195 BI Visit MP&S CNR Doc	Communication Aids Communication aids should be available to help patients with communication difficulties to participate in decisions about their care.	N	Although staff could access an interpreter, there was no evidence of picture boards or other communication aids

Ref	Standard	Met Y/N	Reviewer Comments
XR-196 BI Visit MP&S CNR Doc	General Support for Service Users and Carers Patients and carers should have easy access to the following services. Information about these services should be easily available: a. Interpreter services, including access to British Sign Language b. 'Compliments and complaints' procedures	Y	Dementia friendly rooms are available. Staff are dementia trained. Good support for people with learning disabilities was provided by the Assistant Practitioner However, there were no picture boards and no clear evidence on how to complain / complement
XR-197 BI Visit MP&S CNR Doc	Involving Patients and Carers The service should have: a. Mechanisms for receiving feedback from patients and carers about their treatment and care. b. Mechanisms for involving patients and carers in decisions about the organisation of the services. c. Examples of changes made as a result of feedback and involvement of patients and carers	N	See QS XR-196
XR-201 BI Visit MP&S CNR Doc	Leadership Imaging Services should have a Clinical Director, Superintendent Radiographer and Divisional Manager (or equivalent) with responsibility for staffing, training, guidelines and protocols, service organisation, governance and for liaison with other services.	Y	
XR-202 BI Visit MP&S CNR Doc	Service Leads Leads for the following areas should be identified: a. General Radiology b. Body CT c. Body MRI d. Musculoskeletal Imaging (including trauma) e. Ultrasound f. Radio-Pharmacy g. Interventional Radiology h. Neuro-radiology i. Nuclear Medicine j. Clinical Records Management k. Facilities and Equipment	Y	However, there does appear to be lack of clarity in the management structure although staff were very positive about the people in post in these positions

Ref	Standard	Met Y/N	Reviewer Comments					
<p>XR-203</p> <table border="1" data-bbox="164 280 248 454"> <tr><td>BI</td></tr> <tr><td>Visit</td></tr> <tr><td>MP&S</td></tr> <tr><td>CNR</td></tr> <tr><td>Doc</td></tr> </table>	BI	Visit	MP&S	CNR	Doc	<p>Staffing Levels</p> <p>The service should have sufficient staff with appropriate competences to deliver the expected number of diagnostic, therapeutic and interventional procedures for the usual case mix of patients within expected timescales (QS XR-602). An escalation policy should be in place which ensures flexibility of staffing in response to fluctuations in demand and availability of staff.</p> <p>Staffing levels should be based on a competence framework covering staffing levels and competences expected (QS XR-204), and should ensure an appropriate skill mix of radiologists, radiographers, nurses, PACS/RIS managers and other staff.</p>	<p>N</p>	<p>Radiologist workload (see Immediate Risk in main report):</p> <ol style="list-style-type: none"> National RCR exam per radiologist worst in country Overall manpower – to match the national average – 20 (currently 8) Minimal reporting backlog suggests that the workload is excessive as this would not be sustainable with 8 people working average hours. <p>Reviewers were told that there had have been some complaints from other specialties in terms of cancer reporting</p> <p>Implementation of Annex T – (see concerns in main report)</p> <p>Reviewers heard that there are sonographer vacancies (see concerns in main report).</p>
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Ref	Standard	Met Y/N	Reviewer Comments					
XR-204 <table border="1" data-bbox="167 280 247 459"> <tr><td>BI</td></tr> <tr><td>Visit</td></tr> <tr><td>MP&S</td></tr> <tr><td>CNR</td></tr> <tr><td>Doc</td></tr> </table>	BI	Visit	MP&S	CNR	Doc	<p>Competence Framework and Training Plan</p> <p>A competence framework should cover expected competences for roles within the service. A training and development programme should ensure that all staff have, and are maintaining, these competences. The competence framework and training plan should cover all staff identified in QS XR-203, including:</p> <ol style="list-style-type: none"> a. Assistant and Advanced Practitioner roles b. Use of specific ablative and therapeutic devices c. Ionising radiation awareness d. Hazardous substances awareness e. MRI safety awareness for all staff accessing the MRI area f. Any imaging service-specific aspects of: <ol style="list-style-type: none"> i. Health and safety ii. Moving and handling iii. Infection control iv. Use of drugs v. Information governance, including ensuring confidentiality of patient information and images vi. Resuscitation vii. Safeguarding adults and children 	Y	<p>The induction / training files held with the training manager were all signed and recorded in personnel files. Mandatory training was on line on ESR and reports sent to the department periodically.</p> <p>Reviewers did however identify some gaps in documentation primarily in documents held locally by departments including some for locum sonographers</p>
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XR-205 <table border="1" data-bbox="167 1456 247 1635"> <tr><td>BI</td></tr> <tr><td>Visit</td></tr> <tr><td>MP&S</td></tr> <tr><td>CNR</td></tr> <tr><td>Doc</td></tr> </table>	BI	Visit	MP&S	CNR	Doc	<p>Agency, Bank and Locum Staff</p> <p>Before starting work in the service, local induction and a review of competence for the expected role in diagnostic, therapeutic and interventional procedures should be completed for all agency, bank and locum staff.</p>	Y	
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Ref	Standard	Met Y/N	Reviewer Comments					
XR-206 <table border="1" data-bbox="167 280 247 459"> <tr><td>BI</td></tr> <tr><td>Visit</td></tr> <tr><td>MP&S</td></tr> <tr><td>CNR</td></tr> <tr><td>Doc</td></tr> </table>	BI	Visit	MP&S	CNR	Doc	<p>Emergency Service</p> <p>Staff with appropriate competences should be available outside planned sessions to respond to urgent requests including for advice, review of previously obtained images, carrying out and reporting urgent:</p> <ol style="list-style-type: none"> Plain and specialist x-ray (24/7) CT scanning (24/7) Ultrasound (24/7) Interventional radiology (24/7) MRI (7/7 on site or by network referral) Carotid Doppler (7/7 on site or by network referral) <p>Competences for emergency work should be maintained through appropriate Continuing Professional Development and / or daytime job-planned work.</p>	Y	However, see Immediate Risk section of main report regarding the impact of providing this service on the radiologist workload
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XR-299 <table border="1" data-bbox="167 1086 247 1265"> <tr><td>BI</td></tr> <tr><td>Visit</td></tr> <tr><td>MP&S</td></tr> <tr><td>CNR</td></tr> <tr><td>Doc</td></tr> </table>	BI	Visit	MP&S	CNR	Doc	<p>Administrative and Clerical Support</p> <p>Administrative, clerical and data collection support should be available.</p>	Y	
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XR-301 <table border="1" data-bbox="167 1310 247 1489"> <tr><td>BI</td></tr> <tr><td>Visit</td></tr> <tr><td>MP&S</td></tr> <tr><td>CNR</td></tr> <tr><td>Doc</td></tr> </table>	BI	Visit	MP&S	CNR	Doc	<p>Scientific and Technical Support</p> <p>Sufficient scientific and technical staff with appropriate competences should be available to support equipment quality assurance, maintenance, breakdown, including breakdown outside normal working hours, and replacement. All scientific and technical staff should have regular assessment of competence appropriate to their role in the maintenance of equipment.</p>	Y	
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Ref	Standard	Met Y/N	Reviewer Comments					
XR-302 <table border="1" data-bbox="165 277 248 456"> <tr><td>BI</td></tr> <tr><td>Visit</td></tr> <tr><td>MP&S</td></tr> <tr><td>CNR</td></tr> <tr><td>Doc</td></tr> </table>	BI	Visit	MP&S	CNR	Doc	Support Services Timely access to the following services should be available: a. Radiation protection advice b. Anaesthetic support for patients requiring sedation or general anaesthetic c. IT support d. Porters e. Patient transport f. Security g. Cleaning h. Linen supplies i. CSSD j. Pharmacy, covering advice and supply of drugs and medical gas testing k. Infection control advice l. Medical records	Y	
BI								
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XR-401 <table border="1" data-bbox="165 1012 248 1191"> <tr><td>BI</td></tr> <tr><td>Visit</td></tr> <tr><td>MP&S</td></tr> <tr><td>CNR</td></tr> <tr><td>Doc</td></tr> </table>	BI	Visit	MP&S	CNR	Doc	Facilities and Equipment The service should have appropriate facilities and equipment to deliver the expected number of diagnostic, therapeutic and interventional procedures for the usual case mix of patients within expected timescales (QS XR-602). Facilities and equipment should comply with all relevant Standards and should ensure: a. Appropriate privacy, dignity and security for patients (QS XR-103) b. Protection of other patients, staff and members of the public from radiation and radioactive sources c. Appropriate separation of children and adults d. Facilities and equipment for scanning of anaesthetised and ventilated patients (Major Trauma Centres only) e. Immediate availability of resuscitation equipment for children and adults	N	No capital replacement equipment programme was in place See also further considerations regarding need to check IR 99 guidance relating controlled area lights
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Ref	Standard	Met Y/N	Reviewer Comments					
XR-402 <table border="1" data-bbox="165 280 248 454"> <tr><td>BI</td></tr> <tr><td>Visit</td></tr> <tr><td>MP&S</td></tr> <tr><td>CNR</td></tr> <tr><td>Doc</td></tr> </table>	BI	Visit	MP&S	CNR	Doc	<p>Equipment Management</p> <p>The service should have arrangements for equipment management covering:</p> <ol style="list-style-type: none"> Procurement and management of equipment and consumables Installation assurance Calibration, operation and performance of equipment Cleaning standards Ensuring all equipment used in the MRI examination room is assessed and approved for use in the MRI environment Equipment maintenance (service contracts and maintenance schedules) covering planned maintenance and breakdown or unscheduled maintenance Contingency plans in the event of equipment breakdown Monitoring and management of equipment failures and faults Ensuring safety warnings, alerts and recalls are circulated and acted upon within specified timescales Programme of equipment replacement and risk management of equipment used beyond its replacement date 	N	See XR 401
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XR-403 <table border="1" data-bbox="165 1388 248 1563"> <tr><td>BI</td></tr> <tr><td>Visit</td></tr> <tr><td>MP&S</td></tr> <tr><td>CNR</td></tr> <tr><td>Doc</td></tr> </table>	BI	Visit	MP&S	CNR	Doc	<p>PACS</p> <p>An IT system for storage, retrieval and transmission of patient information should be in use. This system should meet national PACS Standards.</p>	Y	However, reviewers noted that the upgrade was overdue
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XR-404 <table border="1" data-bbox="165 1612 248 1787"> <tr><td>BI</td></tr> <tr><td>Visit</td></tr> <tr><td>MP&S</td></tr> <tr><td>CNR</td></tr> <tr><td>Doc</td></tr> </table>	BI	Visit	MP&S	CNR	Doc	<p>Moving and Handling Aids</p> <p>Moving and handling aids should be available and appropriately maintained.</p>	Y	
BI								
Visit								
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CNR								
Doc								

Ref	Standard	Met Y/N	Reviewer Comments
XR-405 BI Visit MP&S CNR Doc	Equipment for Patients with Severe Obesity The service should have access to appropriate equipment, moving and handling aids and gowns to meet the needs of patients with severe obesity.	Y	See good practice in terms of use of the 'hover mat'
XR-501 BI Visit MP&S CNR Doc	Referral Information Guidelines on information to be sent with each referral should have been agreed and circulated to all referring GPs and referring hospital clinicians.	Y	
XR-502 BI Visit MP&S CNR Doc	Referral Management Protocol A protocol for managing imaging referrals should be in use covering: <ol style="list-style-type: none"> Checking and prioritisation of referrals Action to take when requests are inadequately completed Vetting of referrals, especially for CT and MRI Ensuring renal function (creatinine or eGFR) is recorded before investigations using contrast media Flexibility of appointments to meet patients' and carers' needs and to coordinate with other appointments when possible Identification of patients who are particularly vulnerable and may need additional support The protocol should be specific about urgency of referrals and arrangements for adults and children.	Y	
XR-503 BI Visit MP&S CNR Doc	Consent An Imaging Service consent procedure should be in use. This procedure should be based on the Trust consent procedure and should have appropriate additional detail to ensure compliance with Royal College of Radiologists (2005) ' <i>Standards for Patient Consent Particular to Radiology</i> '.	Y	However, although there was a policy it was not clear that the consent process was being adhered to.

Ref	Standard	Met Y/N	Reviewer Comments
XR-504 BI Visit MP&S CNR Doc	Image Acquisition Protocols Image acquisition protocols should be in use covering: a. Roles and responsibilities b. Patient identification c. Image quality	Y	
XR-505 BI Visit MP&S CNR Doc	Imaging in Pregnancy Guidelines should be in use covering imaging of women who are or who may be pregnant.	N	Guidelines covering Imaging in pregnancy were not available at the time of the visit
XR-506 BI Visit MP&S CNR Doc	Imaging of Children and Young People Guidelines should be in use covering imaging of children and young people, including: a. Action to take if non-accidental injury is suspected b. Reporting by a radiologist with appropriate expertise.	N	Reviewers did not see evidence of an NAI protocol.
XR-507 BI Visit MP&S CNR Doc	Infection Control Guidelines on infection control should be in use, including: a. Imaging of patients with suspected or confirmed contagious and communicable diseases and/or suppressed immune systems, including patient care before, during and after imaging b. Decontamination of equipment and environment following use by patients with suspected or confirmed contagious or communicable diseases	Y	However, see serious concern in main report.

Ref	Standard	Met Y/N	Reviewer Comments
XR-508 BI Visit MP&S CNR Doc	Imaging Reporting Guidelines Image reporting guidelines should be in use covering: <ol style="list-style-type: none"> Roles and responsibilities Agreed reporting formats System to assure quality, accuracy and verification of reports System to ensure amendments are issued within specified timescales (when required) Extra views 	N	Staff were aware of the 'rules' but there was no evidence that this was documented
XR-509 BI Visit MP&S CNR Doc	Interventional Procedures Guidelines should be in use covering: <ol style="list-style-type: none"> Interventional procedures provided by the service Roles and responsibilities Use of '<i>WHO Surgical Safety Checklist: for radiological interventions only</i>' Systems for assuring the quality and outcomes of interventional procedures undertaken Arrangements for accessing a second opinion for complex procedures Arrangements for clinical support in an emergency 	Y	
XR-510 BI Visit MP&S CNR Doc	Network and More Specialist Services Guidelines should be in use covering arrangements and agreed timescales for: <ol style="list-style-type: none"> Access to procedures available at other hospitals within the imaging network Access to specialist advice or procedures not available locally Indications and arrangements for review of imaging by a neuro-radiologist Indications and arrangements for review of imaging by a paediatric radiologist Indications and arrangements for review of other imaging where appropriate expertise is not available locally 	Y	

Ref	Standard	Met Y/N	Reviewer Comments
XR-511 BI Visit MP&S CNR Doc	Unexpected Diagnoses and Potential Medical Emergencies A protocol covering the management of unexpected diagnoses and indications of potential medical emergencies should be in use.	Y	
XR-512 BI Visit MP&S CNR Doc	Pathway and Condition-Specific Guidelines Pathway and condition-specific guidelines should be in use covering at least: <ol style="list-style-type: none"> Trauma (adults and children) Stroke Cancer (including GI malignancy and stenting) Venous thrombo-embolic disease 	N	Evidence not seen by reviewers in folder however some guidelines were on the walls in the treatment rooms
XR-513 BI Visit MP&S CNR Doc	Management of Drugs and Contrast Media Guidelines on the management of drugs and contrast media should be in use covering at least: <ol style="list-style-type: none"> Roles and responsibilities Security and storage Prescription, including prescription of unlicensed medicines Preparation and administration Identification and management of extravasation Identification and management of patients at risk of adverse reactions Aftercare of patients 	Y	However, application of the guideline was not consistent as the contrast warmer did not have temperature gauge on it and other queries were identified in relation to the storage of medicines.
XR-514 BI Visit MP&S CNR Doc	PACS Procedure A procedure should be in use covering, at least: <ol style="list-style-type: none"> Access to and use of PACS Electronic audit trails of PACS usage Use of PACS for teaching, audit and research Transfer of images to other organisations, for example, for specialist review Security of CD copies of patient images 	Y	

Ref	Standard	Met Y/N	Reviewer Comments
XR-515 BI Visit MP&S CNR Doc	Ionising Radiation The service should have an up to date report showing compliance with Ionising Radiation (Medical Exposure) Regulations.	Y	
XR-516 BI Visit MP&S CNR Doc	Hazardous Substances The service should have an up to date report showing compliance with Control of Substances Hazardous to Health (COSHH) Regulations.	Y	
XR-517 BI Visit MP&S CNR Doc	Health and Safety The Trust Health and Safety Policy should be in use with specific reference to: <ol style="list-style-type: none"> a. Response to clinical incidents, including unintended or excessive exposures b. Use and disposal of sharps c. Re-sheathing d. Prevention of repetitive strain injury e. Signage and hazard warnings 	Y	However, see further considerations in main report relating to controlled area lights

Ref	Standard	Met Y/N	Reviewer Comments
XR-601 BI Visit MP&S CNR Doc	Operational Policy An Imaging Service Operational Policy should be in use covering at least: <ol style="list-style-type: none"> Availability of services, including 24/7 availability (QS XR-206) Capacity and escalation plan to ensure imaging timescales are achieved (QS XR-602) Cleaning schedules Protocol for non-medical referrers Contribution to cancer, renal, vascular, cardiac and other multi-disciplinary team meetings as appropriate Arrangements for medico-legal imaging Arrangements for imaging required for research and development Arrangements for staff feedback about the imaging service and for involving staff in decisions about the organisation of the service Arrangements for obtaining feedback from referring GPs and hospital clinicians and for involving referring GPs and hospital clinicians in decisions about the organisation of the service Response to a Major Incident PACS Business Continuity Plan 	N	An operational policy covering all aspects of the QS was not yet in place.
XR-602 BI Visit MP&S CNR Doc	Imaging Timescales Imaging and initial and final reporting timescales should have been agreed including at least: <ol style="list-style-type: none"> Initial reports available within one hour for Emergency Department, Acute Medical Unit and Acute Surgical Unit requests National timescales for diagnostic imaging, including trauma, stroke, TIA and heart failure imaging Other timescales agreed locally 	Y	The Plain film reporting was completed Monday to Friday 9am – 6pm. Reporting also took place Saturday and Sunday to ensure that no images from ED waited more than 24 hours for a report. This appeared to be achieved for most cases.

Ref	Standard	Met Y/N	Reviewer Comments
XR-603 BI Visit MP&S CNR Doc	Risk Assessment and Management A system risk assessment and risk management should be in use covering risk assessment, risk management and review of risks. Risks and actions should be recorded in an up to date Divisional Risk Register. The risk management system should cover at least: <ol style="list-style-type: none"> a. Risks associated with image acquisition (QS XR-504), image reporting (QS XR-508), interventional procedures (QS XR-509), other guidelines and policies (QS 500s) b. Feedback to staff about risks identified and action taken 	Y	Risk register in place and regularly reviewed. Appropriate risks are recorded
XR-604 BI Visit MP&S CNR Doc	Service Improvement The service should have systems for ongoing review and improvement of quality, safety and efficiency, including at least: <ol style="list-style-type: none"> a. Room utilisation b. Staff utilisation c. Review of clinical pathways with referring GPs and hospital clinicians 	Y	
XR-605 BI Visit MP&S CNR Doc	Service Development Plan The service should have a development plan or strategy which brings together the staffing, training, equipment and facilities plans for the next five years in support of the Trust's business plans.	N	
XR-701 BI Visit MP&S CNR Doc	Data Collection Regular data collection and monitoring should cover: <ol style="list-style-type: none"> a. Recording of date of referral, time of image capture, time of report dictation, time of verification and time of report issue b. Monitoring of agreed imaging timescales (QS XR-602) 	Y	
XR-702 BI Visit MP&S CNR Doc	Audit The service should have a rolling programme of audit of compliance with guidelines and protocols [QSs 500s].	Y	

Ref	Standard	Met Y/N	Reviewer Comments
XR-703 BI Visit MP&S CNR Doc	Quality Assurance System The service should have a system to ensure analysis and feedback on the quality of: a. Imaging acquisition (QS XR-504) b. Image reporting (QS XR-508), including double reporting of a minimum of 30 cases per year per reporting healthcare professional for each individual modality reported c. Interventional procedures (QS XR-509) Feedback to individual members of staff should be linked with appraisal and re-validation arrangements.	N	
XR-704 BI Visit MP&S CNR Doc	Radiology Discrepancy Meetings Radiology Discrepancy Meetings should be held at least every two months. Consultant radiologists should attend at least 50% of the meetings held. The meetings should have a formal process of recording the outcome for each case, learning and action points, and confidential feedback. An annual report should be produced.	Y	However, see further considerations in main report regarding new national guidance for recording discrepancy meetings
XR-705 BI Visit MP&S CNR Doc	Monitoring of Key Performance Indicators Key performance indicators, including timescales for imaging and reporting (QS XR-602) should be reviewed regularly with Trust management and with commissioners.	Y	Some KPIs are being monitored. However, evidence was not seen by reviewers (for example minutes of quality or governance meeting minutes)
XR-798 BI Visit MP&S CNR Doc	Review and Learning The service should have appropriate multi-disciplinary arrangements for review of, and implementing learning from: a. Positive feedback, complaints, outcomes, incidents and 'near misses' b. Published scientific research and guidance relating to imaging services	Y	

Ref	Standard	Met Y/N	Reviewer Comments
XR-799 BI Visit MP&S CNR Doc	Document Control All policies, procedures and guidelines should comply with Trust document control procedures.	N	A number of documents reviewed were not dated and document / version control was not evident

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