# 9 Harley Street Limited

## Quality Report

9 Harley Street
London
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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? | **Not sufficient evidence to rate** |
| Are services caring? | **Good** |
| Are services responsive? | **Outstanding** |
| 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.

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

# Summary of findings

## Overall summary

9 Harley Street is operated by 9 Harley Street Limited. The service provides a range of diagnostic imaging services including computerised tomography (CT), magnetic resonance imaging (MR) and ultrasound scanning (USS) to adults and to a very small proportion of children.

The service provides outpatients and diagnostic imaging services only. Our inspection focussed on the regulated activity diagnostic and screening procedures.

We inspected this service using our comprehensive inspection methodology. This inspection was unannounced which meant the provider did not know the date of the inspection in advance.

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 it as **Good** overall.

- There were systems to keep people safe. Mandatory training and safeguarding training for both children and adults had been completed by all staff.
- Equipment was maintained and serviced appropriately and there were safeguards to protect people from the risks from radiation.
- We saw that staff had received training to operate scanning equipment safely and there were opportunities for further staff development.
- Staff worked to appropriate guidance. Consent processes were appropriate and staff had received training in the Mental Capacity Act and associated legislation.
- Staff were caring and patients' privacy and dignity was respected. Feedback from patients was consistently positive.
- Services were planned and delivered in order they met the needs of patients. Adaptations to the environment had been considered and implemented to ensure the clinical setting was appropriate for patients.
- The service managed staffing effectively. Staff with the right skills and experience were deployed appropriately ensuring patients were safe and that their care needs were met.
- When things went wrong, lessons were learnt and changes were implemented to reduce the risk of similar incidents occurring again in the future.
- Risks associated with the delivery of services had been considered with appropriate mitigations in place.
- Staff described a culture of openness and transparency. The leadership team were visible, approachable and responsive.

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

- There were examples when non-registered healthcare professionals were involved in the administration of medicines without the appropriate processes being in place. The provider took immediate action to stop this activity at the time of the inspection.
- The provider was working with consultants to ensure contemporaneous health care records were readily accessible at all times. Improvements were required to ensure all consultants complied with the providers health records policy.

**Dr Nigel Acheson**

Deputy Chief Inspector of Hospitals (London and South)

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Diagnostic imaging** | Good  | **The service provided radiological, magnetic resonance and ultrasound scanning services which were safe.**<br>**There were systems to monitor safety, patient outcomes and patient experience.**<br>**Appropriate, nationally referenced guidelines were used in the delivery of services including those for the control of radiation.**<br>**Staff were caring and privacy and dignity was consistently respected.**<br>**The service was sufficiently responsive to make reasonable adjustments for patients with disabilities or other needs**<br>**Risk, governance and operational performance was well managed.**<br>**There was a cohesive and visible leadership team who were committed to developing clinically-led, highly responsive services.**<br>**There was a culture of improvement and safety was a priority for this service.** |

# Summary of findings

## Contents

Good

# 9 Harley Street Limited

**Services we looked at**
Diagnostic imaging

# Summary of this inspection

## Background to 9 Harley Street Limited

9 Harley Street is operated by 9 Harley Street Limited which is a legal subsidiary of the Phoenix Hospital Group. The service opened in 2008. 9 Harley Street is a standalone diagnostic facility complemented by outpatient consulting rooms. The service provides a suite of diagnostic imaging services including computer tomography (CT), magnetic resonance imaging (MRI) and ultrasound scanning. It is located in central London and is in close proximity to the inpatient service operated by Phoenix Hospital Group.

The hospital has had a registered manager in post since 12 May 2016.

The service has previously been inspected once before on 22 June 2012. The service was meeting all the essential standards of quality and safety inspected at that time.

## Our inspection team

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

## Information about 9 Harley Street Limited

The service is a standalone diagnostic imaging service with a range of outpatient consulting rooms located within the same building. The service forms one part of the wider Phoenix Hospital Group however 9 Harley Street is established as a limited company in its own right.

9 Harley Street provides services to both adults' and children. The total level of activity associated with services provided to children equated to no more than 3% of all activity year on year.

The service provides magnetic resonance imaging, computerised tomography, and ultrasound scanning.

During the inspection, we visited the service. We spoke with eight staff including the registered manager and director of clinical services, chief executive, governance lead, three consultants who worked under practising privileges, the chair of Phoenix Hospital Group and the radiation protection supervisor.

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

Track record on safety:

- No never events
- Clinical incidents: zero no harm, no low harm, no moderate harm, no severe harm, no death,
- No serious injuries
- No incidences of healthcare acquired Clostridium difficile (C.diff)
- Seven complaints
- One Ionising Radiation Medical Exposure Regulations (IR(ME)R) notifiable incident (04 October 2018).

**Services provided at the hospital under service level agreement:**

- Health and safety
- Fire Safety
- Legionella Risk Assessments
- Periodic inspection reporting and fixed wiring testing

# Summary of this inspection

- MR chiller maintenance
- MEDRAD injectors
- Ultrasound and CT maintenance
- Pest control
- Infection control
- Resuscitation advisory service
- Sterile services
- Clinical waste management
- Biomedical engineering
- Radiation protection advisor
- PACS
- Occupational Health
- Confidential waste collection
- Telephone answering overflow 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

We rated safe as **Good** because:

- Infection control was managed with a regular audit programme to ensure the service continued to meet regulatory requirements. The service was visibly clean and tidy and cleaning schedules had been completed.
- Equipment was appropriately maintained and there were records to show that servicing and quality assurance had taken place.
- Local rules were displayed and had been signed by the radiographers.
- Risk to patients were minimised by policies and procedures.
- The service had appropriate warning signs and access to imaging areas was restricted.
- There was a procedure to report incidents and feedback to staff when incidents had taken place.
- Staff levels were planned in relation to the level of activity at the service. The provider adopted a zero tolerance policy to lone working.
- Medicines were stored safely and securely.

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

- We found that non-registered health care professionals were, on occasion, involved in the administration of medicines which had been prepared by named health care professionals. This was addressed at the time of the inspection.
- Radiography health care support workers had not signed the local radiation rules.
- Health care records were not consistently being made readily accessible and available at all times by consultants.

### Are services effective?

Not sufficient evidence to rate

We do not currently collect sufficient evidence to enable us to rate this key question.

- The service used appropriate guidelines from the National Institute of Health and Care Excellence.
- Diagnostic reference levels were used so that patients received the minimum amount of radiation.
- The service had a comprehensive audit plan to support patient safety, quality improvement and patient satisfaction. Audits were supported by action plans.

# Summary of this inspection

- Staff training was in place and there were opportunities for staff to develop.
- Appraisal rates were at 100% and there was a training needs analysis as part of the appraisal process.
- There were processes for consent and staff had received training in the Mental Capacity Act and associated legislation.

## Are services caring?

Good 

We rated caring as **Good** because:

- Patient feedback was consistently good with high numbers of compliments received as part of the patient experience questionnaire programme.
- Staff were supportive, caring and ensured patient's privacy and dignity was maintained.
- Staff had sufficient time to support patients. This was especially true for claustrophobic patients who required MR imaging.

## Are services responsive?

Outstanding 

We rated responsive as **Outstanding** because:

- Services were sufficiently flexible to meet the needs of patients. Clinic opening times could be extended in the event a patient required an urgent scan for example.
- The provider was supporting charity fundraising campaigns, as well as establishing care pathways for vulnerable women, in conjunction with a local church.
- The environment had been designed so it was suitably appropriate for all ages and for those with restricted mobility or other needs.
- Consideration was given to those individuals whose first language was not English.
- The service had a complaints policy and had received five formal complaints in the reporting period. Four of the five complaints were upheld. There was evidence of learning from each complaint with good escalation of patient feedback to the management committee.

## Are services well-led?

Good 

We rated well-led as Good because:

- Staff described a culture of openness and transparency.
- The leadership team were visible, approachable and responsive.
- There was a clear vision for the service which was directed towards the development of a clinically led centre of excellence.

# Summary of this inspection

- Risk, governance and operational performance was well managed.
- There was a cohesive and visible leadership team who were committed to developing clinically-led, highly responsive services.
- There was a culture of improvement and safety was a priority for this service.

# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Diagnostic imaging | Good | Not rated | Good | ☆ Outstanding | Good | Good |
| Overall | Good | Not rated | Good | ☆ Outstanding | Good | Good |

Good

# Diagnostic imaging

| | |
|---|---|
| Safe | Good |
| Effective | Not sufficient evidence to rate |
| Caring | Good |
| Responsive | Outstanding |
| Well-led | Good |

## Are diagnostic imaging services safe?

Good

We rated safe as **good.**

**Mandatory training**

- There was an annual mandatory training programme which included fire prevention and awareness, health and safety awareness, manual handling, and control of substances hazardous to health (COSHH). The provider had a completion target of 90% across all mandatory training. Training completion at the time of inspection was:
  - Fire prevention and awareness 89%
  - Health and safety awareness 89%
  - Manual handling 84%
  - COSHH 89%
- In addition to the statutory courses above, staff also received training in a range of areas which helped them to consider the needs of those individuals with mental health needs, learning disabilities and dementia, as well as consideration of equality and diversity legislation. Completion of these courses was reported as 89%.

**Safeguarding**

- There were robust arrangements for ensuring staff were aware of the systems and processes adopted by 9 Harley Street for identifying and protecting vulnerable individuals. There was an up-to-date policy and safeguarding escalation flow chart which staff were able to readily direct us towards during the inspection.
- Staff were aware of their roles and responsibilities regarding safeguarding both adults and children. Whilst the number of children seen at 9 Harley Street was minimal, staff had a good understanding of the national "Think Child" campaign, and could provide examples of when a child may be vulnerable. Further, staff could describe examples of what may constitute a vulnerable person including those at risk of neglect, financial abuse, child sexual exploitation, female genital mutilation, domestic violence and abuse.
- There was a designated individual within the organisation who had completed level four child safeguarding training and so was the primary senior responsible individual for safeguarding. Eighty-nine percent of clinical staff who had contact with children had completed level three safeguarding children training.
- 89% of staff had completed level one and two adult safeguarding training.
- The organisations safeguarding lead attended local authority designated officer (LADO) facilitated workshops to ensure their knowledge remained up to date.
- The provider had systems which ensured patients identification was confirmed against three points of patient identity including full name, date of birth and address. Patient details were also matched against the original referral form. Patients were asked, as a precautionary measure, to confirm the approximate

site of their intended scan however staff recognised that patients could sometimes be vague where there was a general abdominal CT request for example. The practices of confirming patient identification was consistent with the best practice standards for magnetic resonance imaging (MRI) produced by the Clinical Imaging Board. These processes ensured the right person received the right type of imaging scan.

- There was a chaperoning policy which ensured trained members of staff were present for intimate examinations, or where patients had requested a chaperone. Staff were able to describe the actions they would take should they have any concerns regarding the conduct of individual clinicians, or where staff members considered the practice of such examinations to be disproportionate to the presenting condition.

**Cleanliness, infection control and hygiene**

- There were no reported incidents of healthcare-associated infections reported for this service in the preceding twelve months.
- Hand wash sinks were available in all consulting rooms and in clinical areas.
- Both the outpatient and radiology departments were visibly clean. Regular cleaning of all areas took place.
- There were arrangements for ensuring clinical and domestic waste was stored and disposed of in accordance with statutory requirements. There were colour coded bins for appropriate disposal of waste including clinical waste. Sharps boxes were not overfilled and were dated.
- Personal protective equipment was readily accessible and we observed staff using this for appropriate interventions during the inspection. During the inspection we observed good compliance with bare below the elbow policies.
- There was a process for managing infectious patients or those patients susceptible to infections. Those individuals who required diagnostic imaging procedures were asked to attend either at the end of an imaging list or during periods of very low patient activity in order that equipment and clinical areas could be appropriately cleaned following their procedure.
- The provider commissioned annual infection control audits as a means of providing assurance. The most recent audit was completed in July 2018 and reported 100% compliance against four of twelve separate assessed metrics. The overall compliance rate for the audit was 93%. A number of areas of improvement and corrective actions had been identified as part of the audit including ensuring cleaning schedules captured the cleaning of both low and high surfaces. We noted during the inspection that the base of clinical trolleys and high areas including curtain rails were clean of dust and debris.
- The provider had completed an observational hand hygiene audit on 16 October 2018. Overall compliance was 93%. A number of corrective actions had been identified including reminding staff to decontaminate their hands following the removal of disposable gloves for example.

**Environment and equipment**

- The provider had embarked on a programme of refurbishment across 9 Harley Street. Outpatient rooms were being modernised and redecorated to ensure they were easy to clean, visibly appealing and appropriate for use as clinical consulting rooms.
- There were appropriate arrangements for ensuring clinical equipment was maintained and serviced in line with manufacturer guidelines.
- The provider had a standard operating procedure which ensured that any medical device brought to the location by a consultant was checked and approved before it could be used at the location.
- The provider had protocols for ensuring alerts issued by national patient safety agencies were captured and instigated where necessary. This ensured that any medical equipment being used was safe and appropriate for use or removed from use where necessary.
- There was an annual audit programme for ensuring lead aprons were visibly examined and where necessary, removed from use if they were damaged of not fit for purpose. The most recent audit had been conducted on 25 July 2018 and identified four items

which were removed from use because the outer layers were cracked. The items of protective clothing were reported to the Radiation Protection Supervisor for consideration.

- Resuscitation equipment was readily accessible in the imaging department. An audit completed by the provider confirmed 100% compliance with daily checks, and that trolleys were fully stocked in line with the provider's requirements.
- Local radiation rules had been updated and were on display within the vicinity of the CT scanner. The majority of staff had signed the local rules. However, health care assistants who supported radiographers had not signed the local rules. We fed this back to the provider and registered manager at the end of the inspection who confirmed this would be addressed as a priority.
- Access to the imaging suite was restricted via a swipe access door. Ionising radiation warning lights were located outside the CT room.
- The provider commissioned an external radiologist to act as the organisations Radiation Protection Supervisor (RPS). The RPS undertook annual radiation safety survey's with the most recent having taken place on 28 August 2018; the report for the survey had been issued on 15 October 2018 however a number of actions had already been proposed and instigated, demonstrating a very timely response to the initial feedback of the August visit. The survey concluded that "There are tangible efforts to improve radiation protection standards within the department and there are regular audits of doses, plain radiography techniques etc". It is important to note that due to limited activity, at the time of the inspection, the provider had ceased undertaking plain film X-rays and so focussed on CT, MR, DEXA and ultrasound scanning only and therefore some of the recommendations from the survey were no longer relevant as they were specifically directed towards plain film procedures. In addition, the survey also captured the use of ionising radiation within the provider's second registered location which was not subject to a regulatory inspection on this occasion and so those findings and recommendations have not been included in this report.

**Assessing and responding to patient risk**

- There was a protocol for the monitoring and transfer of deteriorating or acutely unwell patients. The local radiology team had undertaken scenario training in the event a patient deteriorated in the MR scanner. Further resuscitation scenarios had been conducted throughout the clinical areas of 9 Harley Street. Learning opportunities were captured and action trackers instigated following scenario events to ensure staff became proficient in the delivery of immediate life support. These actions included ensuring staff were familiar with equipment stored on the resuscitation trolley for example. A review of minutes from the resuscitation committee meeting held in March 2018 confirmed appropriate learning from two anaphylaxis incidents which had been reported in the OPD during the preceding twelve months. A review of each incident had been carried out and recommendations and learning had been identified. This included reviewing the drugs and equipment stored on the resuscitation trolleys which were aligned to the Resuscitation Council UK guidelines.
- Imaging contrast was only administered to patients when a consultant was based at the location. This ensured that should a patient react to the contrast a medical practitioner could provide immediate care to the patient until they were stabilised and transferred. All staff had completed immediate life support training and basic paediatric life support. Staff asked patients to confirm whether they had any allergies prior to the administration of medicines; this reduced the risk of patients being administered a drug which they may be allergic too.
- MRI patient safety questionnaires were completed by the patient before scanning took place. Patients were assisted by the health care assistant and then completed forms were checked by the radiographers. Other individuals who also required entry to the MR suite were also screened to ensure they were not at risk of harm caused by the strong MR magnet.
- There had been one reported incident whereby a patient was transferred to another healthcare setting following an anaphylactic reaction to contrast. A range of actions was identified as part of the route cause analysis investigation including ensuring patients were transferred to a clinical setting appropriately

equipped to manage life threatening conditions; we saw evidence that the transfer protocol had been updated. The incident and learning had been discussed at clinical governance meetings and staff had been updated and could describe the lessons learnt and changes to practice which resulted from the initial incident.

- The pregnancy status of women was routinely checked and there was evidence of such checks being conducted. Where women were confirmed as being pregnant, there were arrangements in place for ensuring appropriate radiation exposure levels or deferral back to the referring clinician for consideration of alternative diagnostic modalities to reduce the overall exposure of radiation to the foetus. The provider had a "Pregnant Patient Policy" for those individuals referred for MR exposure. The policy set-out the providers position on the carrying-out of MR procedures for women pregnant and within the first trimester.

**Nurse and Allied Healthcare professional staffing**

- The service employed four radiographers, two radiology healthcare assistants, 1.5 senior radiographers, one radiation supervisor, three nurses including one lead nurse, four health care assistants including one senior HCA, one radiology manager, one reception supervisor and 2.8 reception staff. The service was overseen by a clinical director who was a registered nurse and also the registered manager for the location.
- Vacancy rates were relatively low although the service was actively recruiting to two vacant radiographer roles and one registered nurse role. Five healthcare assistants, one registered nurse and two radiographers had left the service during the preceding twelve months. The main reason for leaving the service was reported as career progression or more competitive salaries offered by other providers in the vicinity of 9 Harley Street. The provider had responded to the later exit reason by reviewing salaries and offering more competitive rates of pay to qualified staff.
- The provider mitigated ongoing vacancies by utilising bank staff to backfill shifts. However, it was noted there was no requirement to backfill radiographer shifts during the preceding three months prior to the inspection as activity had been planned alongside the availability of staff.
- The sickness rate for the service was low at approximately 2% for nursing staff, health care assistants and reception staff. Radiographer sickness rates were marginally higher at 5%.

**Records**

- An audit was undertaken by the service in September 2018 which concluded that 39 of 76 consultants routinely sent copies of their clinic notes to 9 Harley Street for storage in patient records. The issue of ensuring medical records were retained on site had been escalated to both the clinical governance committee and to the medical advisory committee with clear actions and communications sent to relevant doctors. The provider also communicated the need for consultants to provide clinical records during the outpatient committee meeting. There was evidence the matter had been discussed with a number of consultants during such a meeting on 19 September 2018. The provider acknowledged that further work was required to ensure that records produced during outpatient clinic appointments were retained within the Phoenix healthcare group premises. A number of consultants had opted to use on-site secretarial support which ensured records were retained on site and was considered by the provider to be a more effective and efficient way of resolving the issue long-term.
- Diagnostic scans and reports were captured on electronic reporting systems which could be accessed by a number of referring clinicians. Where referring clinicians did not have access, copies of the scan reports were sent via post, as well as copies of scans and images also being provided direct to the patient on completion of the imaging episode.

**Medicines**

- Medicines were stored in a locked cupboard in a room with a keypad. The room temperatures were checked and recorded daily. Minimum, maximum and actual temperatures were recorded. Staff informed us any temperature issues were reported to the corporate pharmacy team for advice and resolution.

Good

# Diagnostic imaging

- Allergies were identified on patient records and there was access to emergency medicines.
- Contrast and a range of other medicines were administered to patients by way of a patient group direction. A patient group direction (PGD) is a written instruction for the supply or administration of a licensed medicine (or medicines) in an identified clinical situation, where the patient may, or may not, be individually identified before presenting for treatment. Radiographers assumed the responsibility for preparing a range of medicines and contrast solutions which had been identified for use for a range of CT scans. We noted that on occasion, health care assistants were asked by radiographers to give oral medicines to patients once they had been prepared by the radiographer. This was contrary to legislative practice as the law permits only registered health care professionals identified by way of a formally authorised patient group direction to both supply and administer the medicine. We escalated this issue to the provider during the inspection. The provider took immediate action to ensure this practice stopped and provided assurances that only registered and approved radiographers would supply and administer all medicines moving forwards.

**Incidents**

- There was a policy for the reporting and management of all adverse events and serious incidents including unexpected or avoidable deaths and never events. The policy was in date and had a review date. We saw that the policy included that the registered persons must discharge their statutory duty of candour under Regulation 20: Duty of candour. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There had been no incidents that required the duty of candour to be applied. Staff were aware of the duty of candour.
- There was an electronic system for the recording of incidents and outcomes were discussed at staff meetings. All staff, including temporary workers and consultants could access the incident reporting system. This meant all staff had the ability to record any concerns or clinical or non-clinical incidents in a timely way and without the need for secure computer access. A review of the incident reporting system indicated 10 no harm incidents had been reported between April and November 2018. All except one incident had been fully investigated and closed. One incident remained open due to ongoing actions awaiting to be fully instigated.
- The registered manager was responsible for undertaking route cause analysis investigations (RCA) where an incident required such a level of review. It was noted the registered manager had not received any formal training in undertaking RCA investigations. However, the corporate clinical governance lead was involved in the RCA process and so acted as the professional lead and advisor when such investigations were undertaken. The provider acknowledged the need for the registered manager to attend appropriate training in order that RCAs were conducted in line with best practice standards.
- There had been one IR(ME)R reportable incident logged with the Care Quality Commission during the reporting period of 16 July 2017 to 16 July 2018. At the time of the inspection, the provider had investigated the incident and had made a number of changes to prevent future similar incidents from occurring again. Staff could describe the incident and the remedial actions and safeguards which had subsequently been introduced.

## Are diagnostic imaging services effective?

Not sufficient evidence to rate

We do not currently collect sufficient evidence to enable us to rate this key question.

**Evidence-based care and treatment**

- Policies and procedures were up to date and referenced best practice guidance from a range of bodies including the National Institute of Health and Care Excellence. The service also used a range of guidance provided from the Royal College of Radiologists.
- The service used diagnostic reference levels (DRL's) for each piece of scanning equipment that produced radiation. DRLs are used as a guide to help promote improvements in radiation protection practice. They

can help to identify issues relating to equipment or practice by highlighting unusually high radiation doses. We observed levels for different parts of the body that were scanned by the service. The radiation protection supervisor monitored DRLs on a monthly basis to ensure patients and staff remained safe. Findings of monthly DRLs was considered at the Radiology reference group which was attended by the radiation protection advisor, radiation protection supervisor and lead radiologists.

- Radiographers liaised with radiologists to confirm dosing levels for children. This ensured children were only exposed to the most clinically effective minimal dose of radiation.

**Patient outcomes**

- There was an audit of patient radiation dosage so that the service knew that patients were within the national guideline dosage for radiation.
- The service had a comprehensive audit calendar for health and safety, radiology safety and patient experience.
- The provider carried out regular clinical audits which considered reporting accuracy, communication, clinical utility and image quality indicators. Where there were deviations in clinical opinion, recommendations were made including whether secondary radiology reports should be issued and referred back to the initial referring clinician for consideration.
- Between 1 April 2018 and 2 July 2018, 50 examinations were reviewed by an externally contracted provider to assess the quality and accuracy of examinations. Eight-eight percent of examinations fulfilled the criteria where no clinical disagreement was met. Eight percent of examinations fell in to category 4 (disagreement over Style and/or presentation of the report including failure to describe clinically insignificant features) and 4% (2 examinations) fell within category three meaning clinical significance of disagreement is debatable or likelihood of harm is low or there is a failure to follow agreed escalation procedures. Feedback to individual individuals was provided and remedial action taken where discrepancies had been identified.
- The review found 90% of examinations were independently reported as having clear accurate reports. 10% were reported as being ambiguous and/or did not have a conclusion provided and/or, where applicable, recommendations made for further tests.
- Ninety-six percent of examinations addressed the clinical question posed by the referring clinician.
- Eight-eight percent of examinations were of an appropriate image quality, categorised as “Perfect” by the independent auditors. Twelve percent of examinations were reported as “Sub optimal”, associated with low resolution images. Low resolution images may mean reporting of images may be more difficult due to poor image quality, resulting in missed or incorrect image interpretation. Action plans existed to address recommendations raised within the audit findings.

**Competent staff**

- There was an induction plan for staff which included a health and safety induction, modality safety rules and key policies.
- All the staff we spoke with had completed an appraisal and the manager told us that all the staff had an appraisal. Staff identified training needs and objectives during the appraisal and there were opportunities for staff to access external training. A review of four staff records confirmed that robust appraisals had taken place. There was evidence that where individual performance was not aligned to the expectations of the provider, remedial support plans were in place to help with individual staff development.
- All nursing staff were required to complete a range of competency assessments. We saw records of these competency assessments having been completed.
- Staff reported opportunities for personal and professional development including undertaking post-graduate qualifications.
- We reviewed four staff records to ensure they met the requirements of Schedule Three of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Each file contained details of previous employment histories, photo identification, qualifications, disclosure and barring service checks

and occupational health clearance. All registered health professionals were confirmed as being registered with their appropriate professional regulatory body. There were processes for ensuring checks were carried out at least annually of all registered health professionals to ensure they remained registered.

- One employee had a gap in employment history which had not been explored by the provider prior to employment commencing. The Health and Social Care Act requires providers to obtain full employment histories, together with a satisfactory written explanation of any gaps in employment (Schedule Three, subsection 7, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).
- There were arrangements for ensuring both temporary staff and substantive staff were inducted to the service by way of a formal induction programme. We saw evidence of nursing staff having completed induction programmes.

**Multidisciplinary working**

- The nature of the service meant that opportunities for formalised multi-disciplinary working was limited at 9 Harley Street. However, despite the challenges, a small number of multi-disciplinary meetings occurred which were facilitated by lead radiologists with input from surgical colleagues. Discussion of complex medical cases took place in which consideration was given to the images produced through diagnostic imaging undertaken at 9 Harley Street. Treatment plans and alternative therapies including both surgical and non-surgical interventions were explored. This meant patients could expect treatment plans which were developed not in isolation, but through comprehensive discussions with multiple medical opinions from experienced consultants.

**Seven-day services**

- 9 Harley Street was an elective care centre with no in-patient provision. Services were available Monday to Friday with scope to extend operational hours to Saturdays where demand required it.

**Consent and Mental Capacity Act**

- All staff had received training in the Mental Capacity Act 2005 and consent and deprivation of liberty safeguards.
- Where patients did not have the capacity to consent to a scan or other imaging procedure, the provider would risk assess on a case-by-case basis. The provider could describe the best interest and legislative practices where such a patient would be scanned.
- Radiographers were required to screen and approve MR and CT contrast questionnaires prior to any scan being undertaken. These forms also served as a consent form and detailed the procedure and any likely risks associated with the intended scan.
- Learning was identified following an incident in which a patient experienced a reaction to a contrast administered prior to a scan. It was noted that the radiographers had not identified that the patient had not answered all of the questions on the form. This therefore posed a query as to whether radiographers routinely checked the questionnaires. During the inspection we found that learning had been embedded. During the inspection, we observed two radiographers routinely scanned all questionnaires and where there had been gaps, these had been explored with the patient.

## Are diagnostic imaging services caring?

Good

We rated caring as **good.**

**Compassionate care**

- We observed staff introduce themselves to patients prior to their scan. Staff wore name badges which were visible and clear.
- The environment had been adapted to ensure patients privacy and dignity was maintained. We spoke with one patient who told us they found the staff to be caring and kind. The patient said they would recommend the service and they would use it again.
- The provider undertook regular privacy and dignity audits which captured a range of interactions between

patients and staff. Standard measures included whether staff introduced themselves to patients, whether communication was clear, that patient requests were managed in a professional and courteous way; that eye contact was maintained and whether staff sought the permission of patients before undertaking any intervention. The service attained 100% compliance against all eleven metrics during an audit undertaken in September 2018.

- During quarter one and two the provider received 158 completed patient experience questionnaires. 99% of patients were satisfied with the quality of services provided, the cleanliness of the department and that staff were respectful and maintained dignity during their visit.
- 81% of patients were highly likely to recommend the service, 18% likely and 1% reported neither.
- 96% of patients reported they were given enough privacy when discussing their condition of treatment. 97% of patients reported having confidence in the staff treating them.
- We reviewed the four pages of comments from quarter one and two patient experience questionnaires. Comments were consistently complementary of the service, staff and environment. There was evidence that where recommendations had been suggested by patients, these were discussed at the outpatient committee meeting.

**Emotional support**

- Staff were able to spend time with patients to explain their intended procedure or scan. Where patients were claustrophobic (a phobia of enclosed spaces), patients were counselled and could spend time adjusting to being in the MR scanner before the scan commenced.
- Staff could communicate directly with patients when they were undergoing MR scans by way of an intercom. Staff could provide reassurance to patients as well as provide updates on the duration of scans.

**Understanding and involvement of patients and those close to them**

- 97% of patients reported they were given all the information they needed. 98% of patients felt they had sufficient time to ask their questions and that they were provided answers in a way which they understood.

## Are diagnostic imaging services responsive?

Outstanding ☆

We rated responsive as **outstanding.**

**Service delivery to meet the needs of local people**

- 9 Harley Street provided a suite of services including computed tomography (CT) and magnetic resonance imaging scanning alongside outpatient consultation services. The service was open Monday to Friday with provision for additional services at weekends and evenings.
- The service was centrally located near to public transport services and so was accessible to a range of people who may have opted to utilise transport other than a car. The building was serviced by a lift and so patients with reduced mobility could use the services on offer.
- In considering patient feedback, seating had been changed in the main waiting area as some patients had reported trouble standing from the existing low seats. We saw that a range of furniture was now located in the reception area including some higher chairs, sofa's and individual seats. We observed reception staff directing specific patient groups to the higher chairs.
- 9 Harley Street accommodated patients from a range of different cultural backgrounds. A significant proportion of patients derive from Arabic speaking countries and so Arabic radio was available in the MR suite, as was a copy of the Quran for Muslim patients.
- Considerable consideration had been given to patients attending for CT colonography. In considering the patient journey, refurbishment of the CT suite resulted in the installation of specialist facilities to help aid patient's freshen-up post procedure.

Good

# Diagnostic imaging

- There was a chaperone policy and patients could request a chaperone if they wanted one. If patient's relatives wanted to accompany patients into the MRI scanning room they completed a form that was checked by the radiographer.
- The provider engaged with a range of consultants to support the delivery of "Pro-bono" health care services. This included examples of patients who required reconstructive surgery attending 9 Harley Street for diagnostic imaging and outpatient services without incurring any cost to them. In addition, the provider was engaged in national research programmes, working in partnership with the National Health Service, exploring the use of CT Colonoscopy scanning for charitable fundraising purposes.
- The provider was working with representatives from Marylebone Church to provide services to vulnerable women who used the church's shelter provision. The provider established relationships with Marylebone Church to support the Women's Changing Lives project. This project looks to support vulnerable women who access community support services. As well as undertaking fund-raising activities, the provider has looked for opportunities to donate to the project. In addition, the provider is working to support local vulnerable women through supporting charitable events at which staff can work to undertake pro-bono work, again further supporting the local community.
- The provider was engaged in supporting a national cancer charity focussed on curing colon cancer. The provider made charitable donations in the form of providing CT colonoscopy scans for the more vulnerable or deprived patient group to which one charity worked with. Additionally, outpatient capacity was provided to support consultants who wished to see and consult patients from deprived backgrounds, free of charge.

**Meeting people's individual needs**

- Interpreter services were available however the provider reported in the majority of cases, patients arranged for their own interpreter. Where patients were funded by their sponsoring embassy, the embassy routinely arranged for a licensed interpreter to be present for consultation or scan.
- The MR scanner was a wide bore machine meaning it could accommodate those individuals who suffered from claustrophobia. Health care professionals also spent time with patients prior to their scan offering reassurance, as well as time for the patient to settle in to the scanner before imaging commenced.
- To ensure the service continues to meet the needs of its client base, the provider had agreed plans to upgrade the existing MR scanner in 2019. The MR scanner was designed to be able to accommodate patients weighting up to 250Kg. The provider also had a pathway in place for referring patients exceeding the MR weight limit. Pathways also existed for patients who required an open scanner due to severe claustrophobia or physical needs which may have meant they could not access the existing MR scanner easily.
- The number of children seen at 9 Harley Street each year was small when compared to total activity, with very few children undergoing diagnostic imaging. The majority of children were seen within the outpatient setting, predominantly by the ear, nose and throat specialists. Waiting areas were generically furnished with no separate waiting area for children. However, children lists were co-ordinated with consultants and happened on a routine basis. Children were progressed through the waiting area with minimal delay before being seen by the relevant consultant. A number of consulting rooms had been adapted and decorated so they were child friendly. Age appropriate toys were available in some areas of the service.
- The centre was compliant with the Disability Discrimination Act 1995. The service was provided on the ground floor of the building, had a low-level reception desk and suitable toilet facilities.

**Access and flow**

- Referrals for scans and diagnostic screening were received via a number of channels. Approximately 50% of all referrals were made by consultants with practicing privileges at 9 Harley Street. The remainder of referrals came from individuals with agreed referral request rights. There was a policy of referral criteria which detailed who could request imaging. The

service accepted referrals from medically qualified doctors or health professionals who had received authorisation to act as a referrer, lists of these were available.

- Once referrals have been justified by the radiologist, patients are contacted and preferred dates and times for their scans are discussed and then subsequently organised. This meant patients could choose a time and date which was suitable and convenient to them as compared to working around the availability of the service.
- There was a process for expediting any referrals which were marked as urgent. Patients could routinely be offered a same day scan if they were already attending 9 Harley Street for an outpatient appointment. Examples were provided of when the service had extended its opening hours in order to meet the requirements of the patient.
- No scans or procedures had been cancelled at short notice for non-clinical reasons during the report period of 16 July 2017 to 16 July 2018.
- Four patients had their scan delayed during the same reporting period. This was due to mechanical breakdown or mechanical repair.

**Learning from complaints and concerns**

- The provider had a complaints policy and procedure. "Making a complaint or suggestion" leaflets were available around the service. Patient experience questionnaires were also offered to patients who had the option of completing these forms once they had left the service. Patient questionnaires were managed and analysed by a third party with reports produced quarterly. There was evidence that all patient feedback was considered at the patient experience group and also at the management committee and medical advisory committee.
- A total of seven complaints were received by the service during the reporting period of 16 July 2017 to 16 July 2018. Five complaints were managed under the formal complaints process whilst two were resolved at a local level. Four of the five formal complaints were upheld. Each complaint was managed in line with the providers complaints process and all were responded too within twenty working days. We reviewed two complaints and the associated responses. There was clear evidence the provider had considered each point raised by the respective complainant; actions instigated in response to where lessons had been identified; and a clear apology afforded to each complainant.
- There was evidence that improvements had been made as a result of such recommendations including ensuring drinking water was available in radiology and reviewing and updating the décor of the clinic.

## Are diagnostic imaging services well-led?

Good

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

**Leadership**

- 9 Harley Street formed part of the wider Phoenix Hospital Group which was led by a substantive chief executive. Whilst the chief executive retained overall accountability for the service, they were supported by a clinical director for clinical services who was also the registered manager for the location. In addition, the service was supported by a clinical governance lead and medical director.
- At the time of the inspection, the long-standing medical director had recently retired. Successful recruitment of a new medical director had taken place. The new medical director had not yet taken up post at the time of the inspection, however there were interim arrangements.
- Individuals at a senior level had the skills, knowledge and attributes required to operate an effective service. The leadership team had invested in key individuals so as to ensure the executive team were suitably competent and experienced. The chief executive was candid about the challenges the organisation faced however he was able to describe the actions taken to overcome such challenges.
- The provider had a longstanding responsible officer who was responsible for overseeing the conduct of consultants who were afforded practising privileges. The responsible officer also attended the medical

advisory committee to oversee the awarding of practising privileges as well as acting as an intermediary advisor between the Phoenix Hospital Group and the General Medical Council.

- Staff reported the leadership team as being both visible and approachable, operating an "open door policy". Daily senior management meetings were inclusive of all heads of department working across the Phoenix Hospital Group. This daily meeting ensured good communication of risks, concerns or operational challenges.

**Vision and strategy**

- The vision of the Phoenix Hospital Group was clearly defined and could be described by all staff we spoke with. The vision of the group was to "Deliver a premier and innovative healthcare service adhering to the very highest standards of quality care and clinical excellence". This was to be achieved through "Preserving the rights and dignity of our patients, giving our employees the opportunity to grow and develop professionally, our consultant user's outstanding support, both benefiting patients and our shareholders return on investment".
- The chief executive could describe the business model he adopted and described the future strategy of the organisation. This included the development of new business ventures whilst also building on existing relationships between the service, consultants and the National Health Service. The delivery of the organisations vision was not solely focussed on delivering a financial return to investors. It was clear the management team were committed to developing a centre of excellence. The selective recruitment of world-class clinicians, especially in the field of radiology was a clear priority. Developing new mammography services, establishing one-stop see and treat clinics and building on existing care pathways such as the consultant-led radiofrequency ablation service were all examples of how the service was evolving to become a centre of excellence.

**Culture**

- Staff were open with the inspection team about their experience working at the service. It was apparent that learning from incidents and developing a safe culture was a clear priority for the service. Staff considered the reporting of incidents as being a means to improve both patient safety and experience as compared to it being a culture of blame. Individuals acknowledged the need to be accountable for their actions but also recognised the willingness of the service to support individuals when things went wrong.
- The registered manager provided examples of how she was working to improve the autonomy of nurses within the service following the extraction of lessons learnt from an incident in January 2018. During an incident in which a patient experienced a reaction to contrast, a nurse felt it was clinically indicated the patient receive a dose of adrenalin as recommended by the resuscitation council anaphylaxis treatment guideline. The consultant present considered the adrenaline was not required and could describe their clinical reasoning. By empowering the nurse, updating local guidelines and sending communications to the consultant body, the registered manager was looking to introduce more enhanced ways of professionals working together, especially during challenging situations. It was noted the patient was discharged from the service with no on-going clinical treatment required as a result of their reaction to contrast.
- Staff reported that quality and sustainability worked in equal partnership with one another. Whilst there was regard for financial effectiveness, staff did not feel that this was at the sacrifice of quality. Examples of where the location had remained open to ensure a patient could be scanned was a good example of where patient care and quality was a priority.

**Governance**

- There was a defined and robust governance process which supported the delivery of care at 9 Harley Street. The leadership team had invested in the development of the governance team although it was acknowledged further investment was likely should the organisation grow as part of the wider strategy.
- A suite of committees existed to support the consideration and escalation of operational risks. Engagement of the consultant body was seen as key to ensure the governance processes operated effectively. A review of various committees including the resuscitation committee, outpatient's user group, clinical governance committee and the medical

advisory committee demonstrated strong engagement from consultants. All committees had clearly defined terms of reference and attendance at committees was quorate with good examples of multi-disciplinary representation.

- Concerns and challenges were communicated through the governance processes to the board. An interview with the organisations chair confirmed they were aware and knowledgeable of the risks and challenges of the service, including those risks which posed less of a risk from a corporate perspective but which were important to front line staff.
- Staff meetings occurred on a regular basis. Meetings were minuted and disseminated to all staff so those not in attendance could consider topics discussed. Learning from incidents was included in discussion, as was operational risks, workforce challenges, updates to policies and other topics relevant to the professionals attending the meeting.
- The office of the chief executive maintained the files for all health professionals operating under practising privileges. There was a process for ensuring all doctors had sufficient indemnity insurance and that individuals acted within their defined scope of practice. The medical advisory committee considered all new applications; reviewed any individual subject to GMC license restrictions; and provided support to the chief executive and medical director where concerns over clinical conduct or practice had been raised.

**Managing risks, issues and performance**

- There was a current risk management policy which was complemented by a range of other policies including an incident reporting policy, complaints policy, board assurance framework and corporate risk register.
- Heads of department had good oversight of the risks relevant to their departments. An effective audit programme existed which ensured appropriate assurance could be escalated to the board. Risks were routinely reviewed and mitigations revisited to ensure they remained effective. There was evidence that where clinical incidents had occurred, any unresolved actions which posed a potential risk were escalated to local and corporate risk registers accordingly.

**Managing information**

- The provider had undertaken a range of activities to ensure they complied with the General Data Protection Regulations. Patient registration forms had been revised detailing to patients how they records and personal information would be used and stored. Where personal and medical information was communicated via electronic communications, the provided ensured files were encrypted, reducing the risk of information being accessible by unauthorised individuals.
- The information governance committee group (IGCG) was accountable to the board and provided a framework which ensured the safe and secure management of information within the organisation. The IGCG met quarterly, was ratified by formal terms of reference with minutes of each meeting being recorded and communicated to relevant persons including to the Management Committee.
- Patients were provided with itemised invoices which clearly listed all costs associated with their care and treatment. The provider was able to provide indicative quotations to self-pay patients, as well as being able to work with insurers to obtain relevant approval for treatment costs prior to treatment commencing.
- There were processes for ensuring notifiable incidents were reported to relevant external agencies. This also included the submission of data to the Private Healthcare Information Network.

**Learning, continuous improvement and innovation**

- The provider was engaged in supporting a range of research trials in collaboration with specialist NHS Trusts.
- One consultant radiologist was providing radiofrequency ablation therapy for benign thyroid nodules. A NICE approved procedure which provides a minimally invasive treatment option for patients who traditionally would require surgery for treatment of symptomatic thyroid nodules.

# Outstanding practice and areas for improvement

## Outstanding practice

- One Consultant radiologist was providing radiofrequency ablation therapy for benign thyroid nodules. A NICE approved procedure which provides a minimally invasive treatment option for patients who traditionally would require surgery for treatment of symptomatic thyroid nodules.
- The provider engaged in a range of charitable activity which supported not only the local population but international patients from deprived backgrounds or those living in poverty.

## Areas for improvement

### Action the provider SHOULD take to improve

- Ensure there are processes for investigating any gaps in employment history prior to any employee commencing work.
- Ensure contemporaneous patient notes and records are retained and accessible to the provider at all times.
- Ensure all staff who support the delivery of radiological services are proficient with, understand, and sign local radiation rules.
- Ensure only those named on patient group directives or other medical prescription administer medicines to patients.
- Consider providing appropriate training to all individuals responsible for undertaking serious incident investigations.
- Ensure recommendations from incident investigations are instigated including ensuring staff are empowered to make decisions as determined by national recommendations and guidance.