

# Harley Street Medical Centre






## Quality Report

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

### Ratings

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

### Overall summary

Harley Street Medical Centre is operated by UME Diagnostics LTD.

The service provides diagnostic imaging through magnetic resonance imaging (MRI), computerised tomography (CT), X-Ray and ultrasound only.

The Harley Street Medical centre registered with the CQC in 2006. It was last inspected in July 2012 under the previous CQC methodology. At the time, the service met the standards it was measured against.

We inspected this service under our independent single speciality diagnostic framework and using our comprehensive inspection methodology. We carried out an unannounced inspection on 23 May 2019.

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

# Summary of findings

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

The main service provided was diagnostic MRI, CT, X-ray and ultrasound scans.

## Services we rate

We have not previously rated this service. At this inspection we rated it as **Good** overall.

We found the following areas of good practice:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service had suitable premises and equipment and looked after them well.
- The service had appropriate arrangements in place to manage risks to patients and visitors.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care.
- The service managed patient safety incidents well, and staff recognised and reported them appropriately.
- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff cared for patients with compassion.
- The service planned and provided services in a way that met the needs of local people.
- People could access the service when they needed it.
- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- The registered manager across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

However,

- At the time of inspection, the service did not have assurances of stock management or a local policy defining responsibilities and process for checking medical supplies stock.
- The centre did not have child friendly waiting areas.

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

**Nigel Acheson**

# Summary of findings

**Deputy Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Diagnostic imaging

### Rating

Good



### Summary of each main service

The provision of Magnetic Resonance Imaging (MRI), computerised tomography (CT) scanning, X-ray and ultrasound which are classified under the diagnostic imaging core service, were the only services provided at this service.

We rated this service as good because it was safe, caring, responsive to people's needs and well-led. We do not currently collect enough evidence to enable us to rate the effective key question.

# Summary of findings

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Good 

# Harley Street Medical Centre

**Services we looked at**

Diagnostic imaging

# Summary of this inspection

## Background to Harley Street Medical Centre

Harley Street Medical Centre is operated by UME Diagnostics LTD. The service opened in 2006 and was acquired by UME in 2008. The private service primarily serves the communities of London. It also accepts patient referrals from outside this area.

UME manage, develop, commission and operate hospitals and healthcare projects in the UK and the

Middle East. UME operates a sister company in Coventry, Warwickshire and employs 50 staff in total, the team at Harley Street Medical Centre are all employed by UME who have managed the centre since 2008.

The service has had a registered manager in post since October 2018.

## Our inspection team

The team that inspected the service comprised a CQC lead inspector, and a specialist advisor with expertise in radiological services. The inspection team was overseen by Terri Salt, interim Head of Hospital Inspection.

## Information about Harley Street Medical Centre

The Harley Street Medical Centre provided diagnostic imaging through MRI, CT scanning, X-ray and ultrasound. It was registered to provide the following regulated activity:

- Diagnostic and screening procedures.

The service was located within a building on Harley Street and operated over five floors. In addition, the building housed two separately CQC registered services.

The basement housed the Open MRI with dedicated patient changing cubicles, a WC and storage areas. There was an extremity MRI, however, this was not in service.

The CT scanner was located on the ground floor alongside a recovery treatment area used for cannulating patients.

The first floor housed a private GP which had a separate CQC registration and wasn't observed as part of this inspection. X-ray and consulting rooms were also located on the first floor.

The second floor housed the consultation suite. The ultrasound was located on the second-floor mezzanine level.

The third floor housed a cardiology suite for another provider.

The fourth floor was for consultant and staff access only. The radiologist reporting room, management office, staff rest room, staff WC and shower facility were all located on this floor

Standard operating hours were Monday to Friday from 8am to 8pm.

During inspection we visited all areas relating to Harley Street Medical Centre. We spoke with nine members of staff, including the managing director of UME, the director of clinical services, administrators, radiation protection advisor and radiographers. We also spoke with four patients and reviewed five patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the services second inspection since registration with CQC. The first inspection was in 2012, where the service met all standards inspected against.

Activity (May 2018 to May 2019)

# Summary of this inspection

- In the reporting period May 2018 to May 2019 there were 7,230 scans completed; of these, 4,197 were MRI scans, 765 were CT scans, 1,484 were X-ray scans and 784 were ultrasound scans.
- On average around 15% were NHS funded and 85% self or other funded.

## Track record on safety

- The service reported zero never events from May 2018 to May 2019.
- The service had recorded zero serious incidents from May 2018 to May 2019.
- The service reported zero IRMER/IRR reportable incidents from May 2018 to May 2019.
- The service received twenty complaints from May 2018 to May 2019.

- The service reported zero incidents of health associated MRSA, Methicillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile and Escherichia coli (E-Coli).

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

- Radiation protection advice
- Infection prevention control advice
- Clinical and or non-clinical waste removal
- Housekeeping
- Pharmaceutical supplies and advisory services
- Interpreting services
- Grounds Maintenance
- Laundry
- Pathology and histology
- Maintenance of medical equipment

# 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?

We rated it as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff completed and updated risk assessments for each patient. Ionising radiation risks were well managed.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- There was an open incident reporting culture within the centre and an embedded process for staff to learn from incidents.
- Standards of cleanliness and hygiene were maintained.
- Staff were compliant with best practice regarding hand hygiene.
- There were comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance.

However:

- At the time of inspection, the service did not have assurances of medical supplies stock management or a local policy defining responsibilities and process for checking stock.

**Good**



### Are services effective?

#### Are services effective?

We currently do not rate effective, we found:

- Patients had their needs assessed and their care and treatment was planned and delivered in line with evidence-based guidance, standards and best practice.
- There were systems to show whether staff were competent to undertake their jobs and to develop their skills or to manage under-performance.
- There was effective multidisciplinary team working throughout the centre and with other providers.
- Information leaflets such as understanding your CT scan, understanding your MRI scan were sent to patients with their appointment letters and were available at the centre.
- Staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, took on new responsibilities and on a continual basis.

# Summary of this inspection

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

## Are services caring?

### Are services caring?

Good



We rated it as **Good** because:

- We observed all staff treating patients with dignity, kindness, compassion, courtesy and respect.
- Staff understood the impact that a patient's care, treatment or condition had on their wellbeing and on their relatives.
- We observed staff communicating with patients so that they understood their care, treatment and condition.
- Staff recognised when patients and those close to them needed additional support to help them understand and be involved in their care and treatment and enable them to access this.

## Are services responsive?

Good



We rated it as **Good** because:

- Services were planned to take account of the needs of different people.
- Patients had timely access to scanning.
- Patients we spoke with knew how to make a complaint or raise concerns.
- Patient complaints and concerns were managed according to the UME policy.
- Complaints were investigated, and learning was identified and shared to improve service quality.

However,

- Translation services were not always utilised when necessary.

## Are services well-led?

Good



We rated it as **Good** because:

- The service had a clear vision and a set of values, with quality and safety the top priority.
- Staff told us they felt supported, respected and valued by the organisation.
- There was an effective governance framework to support the delivery of the strategy and good quality care.
- The service had a local risk register and managers had clear visibility of the risks and were knowledgeable about actions to mitigate risks.

# Summary of this inspection

- Patients' views and experiences were gathered and acted on to shape and improve the services and culture.

# Diagnostic imaging

Safe	Good	
Effective		
Caring	Good	
Responsive	Good	
Well-led	Good	

## Information about the service

Start here...

## Summary of findings

Start here...

# Diagnostic imaging

## Are diagnostic imaging services safe?

Good 

We rated it as **good**.

### Mandatory training

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

Mandatory training was a mixture of 'face-to-face' and 'e-learning' training modules. These included: basic life support, complaints handling, conflict resolution, equality and diversity, infection control, information governance, fire safety at work, health and safety, safeguarding adults, and safeguarding children training. This was in line with the NHS Core Skills training framework.

Clinical staff were also required to complete additional mandatory training, including: immediate life support, medicines management in imaging, moving and position people, intravenous cannulation and anaphylaxis training on an annual basis.

The Centre had a bank of temporary staff which was used in the event of annual leave or sickness. Bank employees followed compliance checks on appointment and followed the services requirements for mandatory training and competencies.

Compliance was recorded using United Medical Enterprises Group (UME) mandatory training tracking system and was reviewed at the corporate level. At the time of our inspection, the service reported a compliance rate of 100% for their mandatory training.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.**

There were safeguarding policies for both adult and children which outlined staff responsibilities with regards to raising concerns and reporting to the local authority and or police as appropriate. The policy also stated requirements for all staff to comply with the enhanced

Disclosure and Barring Service (DBS) checks before working for the organisation to reduce risks to patients. We saw documentation verifying that all staff had undergone a DBS check.

The service took referrals for patients under the age of 18. The registered manager and executive team was trained in safeguarding children level 3, the radiographers were compliant in safeguarding children level 2 and the administrators had completed safeguarding children level 1. There was a procedure for child protection referrals if needed. The staff knew where to find this.

On inspection, we saw the safeguarding management process published and displayed in all staff areas. This included the escalation process and relevant contact details for local agencies for children and adults.

Staff we spoke with had not made any safeguarding referrals; however, staff were able to confidently tell us how they would identify a safeguarding issue and what action they would take. Staff told us that any safeguarding concerns would be recorded on the incident reporting system (DATIX).

Staff were aware of the concerns around female genital mutilation (FGM) and had access to a flow chart for information when escalating concerns. If staff were concerned about any patients, they would immediately escalate concerns to the centre manager.

### Cleanliness, infection control and hygiene

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

We observed all areas of the service to be visibly clean.

The Centre staff were responsible for cleaning the MRI scanner; both equipment and general areas, to avoid safety risks with housekeeping entering the controlled area. The centre team cleaned the MRI room at the end of each day. This was recorded on a daily check sheet.

Staff followed manufacturers' instructions and the centres guidelines for routine disinfection. This included the cleaning of medical devices between each patient and at the end of each day. We saw staff cleaning equipment and machines following each use.

# Diagnostic imaging

We reviewed all machines in use and saw where appropriate the machines had been disinfected.

We observed the processes of decontamination of ultrasound probes to be thorough and robust and saw documented evidence of completion of decontamination.

We observed x-ray cassettes were wiped in between exposures.

All the patients we spoke with were positive about the cleanliness of the centre and the actions of the staff with regards to infection prevention and control.

All the staff we observed demonstrated compliance with good hand hygiene technique in washing their hands and using hand gel when appropriate. Staff were bare below the elbow and had access to a supply of personal protective equipment (PPE), including gloves and aprons. We saw staff using PPE appropriately.

Hand hygiene audits were completed to measure staff compliance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene.' These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene to reduce risk of cross contamination between patients.

Waste was handled and disposed of in a way that kept people safe. Waste was labelled appropriately, and staff followed correct procedures to handle and segregate different types of waste.

The centre had local policies relating to infection prevention and control (IPC). Staff had access to the infection control lead who was on a service level agreement for advice and support. An annual inspection of premises was undertaken with associated reports and actions plans made available to staff. The Director of Clinical Services was the link person who contributed to the completion of action plans.

The infection control advisor attended the quarterly integrated governance committee. Outcomes were published on the staff notice board and minutes were on the shared drive for staff to access. All staff received Infection Prevention Control training annually both as e-learning and face to face training.

The Centre had an annual audit schedule which included appropriate audits relating to infection control. These included a hand washing audit, sharps audit and waste audit. The audits results were discussed at the medical advisory committee (MAC), Integrated governance committee, heads of divisions (HODS) meetings with the audit results published monthly and posted on staff notice board.

## Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

The layout of the centre was compatible with the Department of Health (DoH) health building notification (HBN06) guidance.

The MRI unit was in the basement, the CT scanner was on the ground floor, the x-ray suite with C-arm was on the first floor and the ultrasound was housed on the second-floor mezzanine level. All clinical areas had access via stairs, chair lifts and elevators.

The CT and MRI scanner had a scanning observation area which ensured patients were visible to staff during scanning.

The fringe fields around the MRI scanner were clearly displayed, (this is the peripheral magnetic field outside of the magnet core. This reduces the risk of magnetic interference with nearby electronic devices, such as pacemakers. Although the strength of the magnetic fields decreases with distance from the core of the magnet, the effect of the "fringe" of the magnetic field can still be relevant and have influence on external devices). There were diagrams in the observation area which clearly defined the MRI environment and controlled access areas by colour coding the areas.

Staff had enough space to move around the scanners and for scans to be carried out safely. During scanning all patients had access to an emergency call alarm, ear plugs and ear defenders. Patients could have radio stations and music of their choice played whilst being scanned. There was also a microphone that allowed contact between the radiographer and the patient.

In accordance with Medicines and Healthcare products Regulatory Agency (MHRA) guidance, 5.4.6, scanning

# Diagnostic imaging

rooms were equipped with oxygen monitors to ensure that any helium gas leaking (quench) from the cryogenic Dewar (this is a specialised type of vacuum flask used for storing cryogenics such as liquid nitrogen or liquid helium), would not leak into the examination room, thus displacing the oxygen and compromising patient safety. The scanning room was also fitted with an emergency quench switch which was protected against accidental use and initiated a controlled quench and turned off the magnetic field in the event of an emergency. The magnet was also fitted with emergency “off” switches, which suspend scanning and switch off power to the magnet sub-system but will not quench the magnet. Staff we spoke with were fully aware of actions required in the event of an emergency quench situation.

An MRI safe wheelchair and trolley were available for patients if they would need to be transferred from the scanner in an emergency.

All equipment conformed to relevant safety standards and was regularly serviced. All non-medical electrical equipment was electrical safety tested. We viewed servicing records for the MRI and CT scanner. These included downtime and handover time.

There were systems in place to ensure repairs to machines or equipment were completed and that repairs were timely. This ensured patients would not experience prolonged delays to their care and treatment due to equipment being broken and out of use.

Servicing and maintenance of premises and equipment was carried out using a planned preventative maintenance programme.

During our inspection we checked the service dates for equipment, including scanners. All the equipment we checked was within the service date. The generators were also tested monthly on a planned schedule to ensure patient scanning was not affected.

We checked the resuscitation equipment on the MRI unit. The equipment appeared visibly clean. Single-use items were sealed and in date, and emergency equipment had been serviced.

Records indicated resuscitation equipment had been checked daily by staff and was safe and ready to use in the event of an emergency.

There were procedures in place for removal and support of a patient that became unwell.

All relevant MRI equipment was labelled in accordance with recommendations from the Medicines and Healthcare products Regulatory Agency (MHRA). For example, ‘MR Safe’, ‘MR Conditional’, ‘MR Unsafe’. All equipment in the assessment area was labelled MR safe.

Access to the MRI, X-ray, CT and ultrasound room was via a locked door. There was signage on all doors explaining the magnet strength and safety rules and a do not enter sign when radiation was on.

Room temperatures and humidity checks were recorded as part of the daily MRI checks. We reviewed room temperature records on the daily check sheet and saw temperatures had been checked and were within the required range. We spoke with staff who told us that where temperatures were not within the required range the scanner would not work and this would be escalated to the registered manager and the service company.

Cleaning chemicals subject to the Control of Substances Hazardous to Health Regulations 2002 (COSHH) were stored in a locked cupboard.

Sharp bins were clean, dated, not overfilled, and had temporary closures in place to prevent accidental spillage of sharps. However, in the ultrasound room we saw the sharps bin had not been labelled with the date of opening. This was immediately actioned and rectified.

Waste was handled and disposed of in a way that kept people safe. We saw staff using the correct system to handle and segregate clinical and non-clinical waste. The centre had a service level agreement for safe disposal.

At the time of our inspection, we found out of date stock within CT, MRI and clinic rooms. Stock included syringes, lubricating jelly, spinal needles and surgical drapes. The day following the inspection the management team, supported by clinical and non-clinical staff made a thorough check of the building removing any stock due to expire in the next three months. The Management of stock had been reviewed and a local policy developed defining responsibilities and process for checking stock was made available for us. The changes in stock management had been discussed with the centres team and was discussed in detail at the HODs meeting and was

# Diagnostic imaging

escalated to the Integrated Governance committee. Following review of minutes and updated policy with action plan we were assured of the responsiveness to our concerns.

The service received referrals for patients aged under 18. The service undertook 98 scans on paediatric patients during the reporting period. On inspection, we saw there were no child friendly areas within the centre for paediatric patients to wait. We saw no toys or children's books within any waiting area. Staff told us children would be supported by parents and or carers.

## Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**

The centre had a daily operations meeting attended by key senior staff. It detailed the activity planned throughout the day, highlighting any concerns specific to patient care. It detailed staffing in all areas and advised the team of any contractor or works carried out within the building that day.

At the end of each day a report was published confirming activity and highlighting any concerns that were raised during the day. Any technical building issues or late reporting was shared with and reviewed by management team and leadership daily. Shared learning was then discussed at the subsequent operations meeting and disseminated to the wider team.

Staff assessed patient risk and developed risk management plans in accordance with national guidance. For example, the unit used a magnetic resonance imaging patient safety questionnaire. Risks were managed positively and updated appropriately to reflect any change in the patient's condition including managing a claustrophobic patient. Patients referrals were checked at the point of referral for any potential MRI safety alerts that required further investigation. For example, whether the patient had any implants or devices. Patient with implants or devices would be declined an appointment by the centre until it was established with the referrer that these were MRI and CT safe.

Patients had the choice of wearing their own clothes or changing into a gown prior to the diagnostic procedure. Patients requiring a procedure were given a welcome pack, which included a disposable gown, non-slip socks and a bag to contain their belongings. This was locked in a patient locker during procedures. Most of the patients we saw during the inspection wore their own clothes.

All patients told us they were given information, risk assessed and had signed a form to accept they had understood the risks for example regarding their choice of clothing and MRI scanning.

There were processes to ensure the correct person got the correct radiological scan at the right time. The service had a Society of Radiographers (SoR) poster within the unit. The posters acted as an aide memoire for staff reminding them to carry out checks on patients.

We also saw staff using the SoR "paused and checked" system. Referrer error was identified as one of the main causes of incidents in diagnostic radiology, attributed to 24.2% of the incidents reported to the CQC in 2014. The six-point check had been recommended to help combat these errors. Pause and Check consisted of the three-point demographic checks to correctly identify the patient, as well as checking with the patient the site or side of their body that was to have images taken, the existence of any previous imaging the patient had received and to enable the MRI operator in ensuring that the correct imaging modality was used.

The centre ensured that the 'requesting' of an MRI was only made by staff in accordance with the MHRA guidelines. All referral forms included patient identification, contact details, clinical history and the type of examination requested, as well as details of the referring clinician or practitioner.

Signs were in the scanning area highlighting the contra-indications to MRI including patients with heart pacemakers, patients who had a metallic foreign body, and patients with an aneurysm clip in their brain. These patients could not have an MRI scan as there was a risk that the magnetic field may dislodge the metal.

In accordance with the National Institute for Health and Care Excellence (NICE) acute kidney injury (AKI) guidelines and the Royal College of Radiologists standards for intravascular contrast agent administration, all high-risk patients referred for MRI were blood tested

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for kidney function prior to scanning. This was to reduce the risk of contrast induced nephropathy (CIN). CIN is a renal impairment or acute kidney injury occurring within 48 hr of administration of intravascular radiographic contrast material that is not attributable to other causes.

We saw evidence the potential risks of intravascular administration of contrast were weighed against the potential benefits. Systems were in place, including trained individuals that were able to recognise and treat severe contrast reactions, including anaphylaxis. At centre this role was fulfilled by a radiographer who had been appropriately trained. Scans that required contrast were only performed when a doctor or radiologist were on site, as they were paediatric resus and ILS trained.

Emergency procedures were robust. The centre had a formal daily resus team covering operational hours which had the support of a registered doctor as team lead in an emergency scenario. There was an emergency nurse call system in all rooms which alerted staff via an emergency pager system.

A quarterly resus scenario was conducted to test the resus capability in differing areas of the building. This was supported and reported with actions by an external provider.

Interventional procedures undertaken within the centre complied with the WHO safer surgery process and a system was in place to manage the process and record the checks completed. This was signed by staff member and consultants.

There was a policy in place to transfer patients to the nearest acute hospital in the event of a medical emergency. All staff were basic life support (BLS) or intermediate life support (ILS) and automated external defibrillator (AED) trained. Staff would put their training to use until an ambulance arrived.

There was a defined pathway to guide staff on what actions to take if unexpected or abnormal findings were found on a scan. The pathway included the contact numbers for radiologists. Reports for such findings were completed urgently to ensure further investigations or treatment was provided promptly.

The service ensured that women (including patients and staff) who were or may be pregnant always informed a member of staff before they were exposed to any

radiation in accordance with the Ionising Radiation Medical Exposure Regulations (IR(ME)R). IR(ME)R sets out the responsibilities of duty holders (the employer, referrer, IR(ME)R practitioner and operator) for radiation protection.

The service had named staff fulfilling the essential roles of radiation protection advisor, medical physics expert, radiation protection supervisor, senior radiologist and infection control lead. The service had appointed a radiation protection supervisor (RPS). Staff said the radiation protection advisor (RPA) and the medical physics expert (MPE) were readily accessible via the telephone for providing radiation advice.

There were local rules (IRR) and employer's procedures in place (IR(ME)R) which protected staff and patients from ionising radiation.

Staff told us there was no lone working at the centre.

The recruitment process for radiographers included pre-employment checks to provide assurances that they were safe and suitable to work for the service. These included, proof of identity including a recent photograph, a Disclosure and Barring Service (DBS) check, references and registration with the Health and Social Care Professional Council (HCPC).

There was a local major incident plan and a company business continuity plan in place to reduce disruption to services if key facility services fail. This was available to all staff and all staff we spoke with could reference it.

## Staffing

**The service had enough allied health professionals with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.**

The centre operated Monday to Friday from 8am to 8pm, the business office operated Monday to Friday 8am to 6pm. The staffing hours were arranged to suit the needs of each service line.

The service followed United Medical Enterprise's safe staffing requirement pathway to ensure staffing levels in

# Diagnostic imaging

the unit were safe. Usual shift staffing consisted of two radiographers, four nurses, two front of house administrators, facilities manager and Director of Clinical Services.

The service employed 31 permanent members of staff. These included six radiographers, four healthcare assistants and five administrative staff. The imaging manager post was being recruited to.

Senior management told us the service always aimed to staff the department at optimum level with appropriate skill mix to offer safe, high quality care, with the intention of meeting the needs of the service users always.

Consideration for staffing of the service was continually reviewed; a staff rota was completed monthly to cover the activity requirements of the service, and then checked each evening to ensure the staff numbers and skill mix reflected the scanning needs for the day ahead.

The imaging team followed a rotational shift rota covering the full operational hours covering all modalities including MRI, CT, ultrasound and X-Ray.

All staff were fully qualified at degree level within radiology and registered with the HCPC. All members of the team completed clinical competencies and undertook annual mandatory training relevant to their role including ILS, anaphylaxis and IV cannulation and venepuncture.

Annual leave was covered by existing staff undertaking overtime or a bank radiographer. The centre had not encountered any periods of extended leave or sickness. If the situation arose consideration would be given to agency staff to cover clinical hours. The centre had arrangements with approved agencies to provide appropriately trained staff as required.

All temporary staff completed an induction including competency sign off on the specialist Imaging equipment used within the centre.

The health care assistant team comprised of four staff including a senior health care assistant who supervised the team. The senior health care assistant reported directly to the Director of Clinical Services. The team followed a rotational shift rota which was flexible to suit the activity within the consulting room schedule.

There was no lone working; there were always a minimum two members of the team in the department. During core operational hours, there were two radiographers, four nurses and two front of house administrators on duty, which provided a safe working environment and clinical support to the team.

The centre did not have access to a registered children's nurse to provide advice when children or young people were utilising the service.

## Medical Staffing

**The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.**

A consultant located full time within the facility supported the service for resus capability as part of his agreement with the centre.

There were a team of consultants working with the team under practicing privileges arrangements. This meant the provider was assured that the consultants had the right qualifications, skills and experience which were necessary for the work performed by them. The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice, or within the provision of community services. The centre held details of the consultant GMC numbers, insurance and details of the NHS trusts they worked for. Practising privileges files seen on inspection were completed and maintained to a high standard.

There was a consultant acting as the lead radiologist and chairman of the medical advisory committee (MAC) and was accessible to management and staff for any concerns, queries or advice.

The radiologists were especially responsive and attended various reporting sessions throughout the week. Consultant support was always available, and advice could be obtained readily across the centres core scanning hours and beyond.

# Diagnostic imaging

Consultants support was available throughout the day from the attending Consultants and Radiologists and the onsite teams work closely with and ask advice on patient care.

## Records

**Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care.

Electronic records were available to staff providing care within the centre, all patient images from MRI, CT, ultrasound and X-ray modalities were stored securely on the PACS systems, only accessible to restricted staff and Consultants.

Patients completed a safety consent checklist form consisting of the patients' answers to safety screening questions and recorded the patients' consent to care and treatment. This was later scanned onto the electronic system and kept with the patients' electronic records.

Patients were asked to read and sign a privacy information statement on their registration form, which stated that any personal information would be protected and used in accordance with GDPR 2018 regulations. A general data protection regulations (GDPR) housekeeping poster was on display in staff areas to remind staff of the role they play in protecting patient data.

Patients' personal data and information were kept secure. Only authorised staff had access to patients' personal information. Staff training on information governance and records management was part of the mandatory training programme.

There was a United Medical Enterprises data protection and privacy policy, which was updated in 2018 in line with the update in general data protection regulations (GDPR). This policy was available to all staff and staff had completed updated mandatory training that complied with GDPR.

The quality of images was peer reviewed locally and quality assured on a corporate level. Any deficiencies in images were highlighted to the member of staff for their learning.

All email correspondence was encrypted by secure email and this was used whenever patient sensitive information was communicated. The centre was a registered user of the NHS electronic referral system (ERS). The centre transferred patient reports and images to referrers by secure picture archiving and communication system (PACS). The radiology information system (RIS) and PACS system was password protected.

Patient sensitive documents sent out in the post were sent by recorded delivery. The centre operated a "clean desk" policy to reduce risk of data breaches.

Quarterly audits were performed to ensure that processes were adhered to.

Scan reports were distributed securely to referring consultants who then discussed results with their patients. Consultants may also access the system to enable them to share images with their patients; providing clarification and understanding of conditions.

If the referring clinician is a GP, reports would be sent using encrypted email or recorded delivery postal service. The service did not routinely send copies of scan reports to patients GPs, just a copy to the referring clinician.

During our inspection, we reviewed six reports and MRI scans. We found all scans and reports were clear and of acceptable quality. Each report included patient identification, reason for the scan, clinical information, as well as a description of findings, conclusions, and recommendations.

## Medicines

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

The service followed best practice when prescribing, administering, recording, and storing medicines.

The Director of Clinical Services was the centre's lead for the safe and secure handling of medicines.

There was a local policy on administration of intravenous contrast and the side effects of contrast in relation to kidney damage (nephrotoxicity). This was up to date.

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There was a local policy on safe management of medicines which was shared with all new staff and available to access by all staff. All medicines were stored, administered, and disposed of in accordance with policy. Drugs were stored in a locked cupboard within a secure room with log book to record all access which was held at the front of house area.

On inspection, we saw an audit record of the centre's stock and this was checked for accuracy.

Medicines including emergency drugs packs were supplied by an external pharmaceutical provider with an ongoing service level agreement for provision of pharmaceutical advice and support services. An annual inspection of premises for storage and management of pharmaceuticals was undertaken in quarter four 2018 with associated report and action plans discussed at MAC and integrated governance committee. The report was published on the staff notice board and was available to staff on the shared drive.

The centre had patient group directives (PGDs) for the administration of contrast with both MRI and CT modalities. The PGDs were approved by the external pharmacist advisor and this provided cover for all staff involved with administration of contrast. At the time of inspection, the PGDs had been updated to conform to the new national standards patient group directive in line with recommendations from the Royal College of Radiologists.

We saw contrast was stored appropriately and was warmed prior to use.

Allergies were clearly documented on the referral forms and on the electronic patient records. Staff verbally checked allergies during the patient safety questionnaire. Radiographers checked patients' details, according to best practice.

No controlled drugs were stored and/ or administered as part of the services provided by the centre.

## Incidents

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised**

**and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored**

The centre had an electronic incident reporting system which was accessible to all staff. A positive culture of reporting an incident and near miss events was in place. Senior staff told us all incidents were investigated and closed within 72 hours of receipt unless circumstances determined the investigation require a longer time.

The centre reported all incident and near miss events on the electronic Datix incident reporting system. All staff had access to report incidents. All incidents, notable trends and lessons learnt were shared with staff at local staff meetings and were included within the integrated governance report which was produced on a quarterly basis.

In accordance with the Serious Incident Framework 2015, the service did not report any serious incidents in the 12 months prior to our inspection. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

There had been no 'never events' in the previous 12 months prior to this inspection. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

There had been no notifiable safety incidents that met the requirements of the duty of candour regulation in the 12 months preceding this inspection. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

All clinical staff we spoke with understood the duty of candour process and the need for being open and honest with patients when errors occurred.

## Safety Thermometer

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**The service did not complete the safety thermometer as this was not applicable to the service they provided their patients.**

The service recorded and reviewed daily safety checks, for example: emergency buzzer, intercom, cold head chirping, arrest trolley, temperature and air conditioning.

## Are diagnostic imaging services effective?

We do not rate effective for diagnostic services.

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients' subject to the Mental Health Act 1983.**

The centre provided care and treatment based on national guidance and evidence including NICE guidance and IRMER. The service followed the required updated IRMER measures providing fully compliant radiation protection for patients undergoing medical exposure in the X-Ray and CT Modality.

Local approved protocols were used for all imaging procedures based on guidance from the Royal Society of Radiologists and were reviewed and signed off by the lead consultant radiologist.

Quarterly peer review audits of imaging reports were undertaken and were scored on several areas including clinical outcome, quality of report and image quality. This report was included within the quarterly integrated governance report which was discussed at the MAC and integrated governance committees. The published report was shared with all staff and we saw this posted on the staff notice board.

Staff we spoke with demonstrated a good understanding of the national legislation that affected their practice, including guidance produced by the National Institute for Health and Care Excellence (NICE) and the Society and College of Radiographers (SCoR). For example, in line with NICE guidance, staff ensured all patients who required contrast media received a blood test to check their kidney function before proceeding with the scan.

Radiographers followed evidence-based protocols for the scanning of individual areas or parts of the body. They also had access to radiologist advice by email, telephone, or face to face if they had any concerns.

Diagnostic Reference Levels (DRLs) were in place and accessible. The DRLs covered all the basic examinations performed.

Guidelines and policies were in line with current legislation and national evidence-based guidance from professional organisations, such as the Medicines and Healthcare Products Regulatory Agency (MHRA) 'Safety guidelines for magnetic resonance imaging equipment in clinical use' (2005).

All local and UME diagnostic policies were up to date and regularly reviewed on a three yearly basis and mirrored any legislative and best practice guidance. All staff had access to the policy library and had knowledge of their content in relation to their role. In the last 12 months necessary changes had been implemented to IRMER related policies and processes in line with the updated IRMER regulations introduced in January 2018 with the guidance and support with the radiation protection advisor.

We saw no evidence of any discrimination, including on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief, and sexual orientation when making care and treatment decisions.

### Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.**

Patients had access to drinking water and a tea and coffee making machine whilst awaiting their examination. During our inspection we observed staff offering patients drinks before and after they were examined.

The service arranged CT colonography appointments in the morning to enable patients to manage the diet and laxative preparation with minimum disruption. Diabetic patients were always allocated the first slot on the appointment list to enable them to manage their diet and medication needs safely.

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## Pain relief

### **Staff assessed and monitored patients regularly to see if they were in pain.**

Pain assessments were not undertaken at Harley Street Medical Centre. Patients managed their own pain and were responsible for supplying any required analgesia. We were told patients with a booking would receive a letter prior to the procedure advising them to continue with their usual medications.

## Patient outcomes

### **Management monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**

The service monitored all patient appointments and completed activity levels monthly. These monitored reports were used to bench mark throughout the year to determine trends in activity and areas where improvements to utilisation could be made.

All failed or incomplete scans were reported on the electronic incident reporting system. This allowed for a trend analysis and identified learning actions. This information was shared in a monthly report with staff involvement.

Radiologists undertook a peer review audit on imaging and reports on a quarterly basis. It measured the following areas; technical quality of images, clinical opinion of images, and language used in the reports. This audit was reported within the integrated governance report compiled by the Director of Clinical Services on a quarterly basis.

## Competent staff

### **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

All staff had detailed personnel files which included evidence of pre-employment checks including references, occupational health review, professional registration

checks, and enhanced disclosure barring system checks. All staff undertook an annual appraisal and mandatory training and had their professional registration checked bi- annually upon renewal.

Enhanced DBS checks were obtained before employment, and regularly in line with UME's HR policies. All staff completed competencies on use of medical equipment at point of employment and were reviewed annually.

The centre had a local induction checklist which was mandatory for all new staff to complete. The local induction ensured staff were competent to perform their required role. The local induction included an introduction to the work location, health and safety, governance and code of conduct.

Once the probationary period was complete staff were monitored daily and any concerns were brought to the forefront immediately to ensure the correct corporate path was followed. If there were any repeat area of concern, then a more formal discussion took place to ensure their performance was always safe and effective.

Staff had the opportunity to attend relevant courses to enhance the professional development and this was supported by the organisation and local managers.

Staff at the centre, including non-clinical, had completed chaperone training which was part of the electronic safeguarding training. The registered manager told us additional face to face chaperone training had been arranged for all staff. Staff said they were prepared and confident in chaperoning.

Data received from the centre showed all radiographers had received an appraisal in April 2019. Any new radiographers received a probationary period review for the first three months of employment followed by an appraisal set until the next review in April of each year.

Staff had the right skills and training to undertake the MRI, CT scans, X-rays and ultrasound. This was closely monitored at a corporate level and locally by the operations manager. Staff skills were assessed as part of the recruitment process, at induction, through probation, and then ongoing as part of staff performance management and appraisal and continuous professional development (CPD) process.

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The radiographers who inserted intravenous access devices into patients had all completed and passed cannulation training and competency assessments. We reviewed these during our inspection and saw they were all in date.

The centre used agency radiographers. There was a formal agency induction checklist, that we saw evidence of completion. Following feedback from an inspection of sister UME site, the UME director of clinical services developed an equipment competency checklist for all agency staff to complete. This was now in use and would be retrospectively completed for agency staff that had worked at the centre previously.

All radiographers were registered with the Health and Care Professions Council (HCPC) and met HCPC regulatory standards to ensure the delivery of safe and effective services to patients. Radiographers also had to provide the centre with evidence of continuous professional development (CPD) at their appraisals.

## Multidisciplinary working

**Medical staff and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff of different disciplines and from different providers worked together as a team to benefit patients.

The service had good relationships with other registered providers housed within the location.

The service had good relationships with other external partners and undertook scans for local NHS providers and private providers of healthcare.

Staff told us there was good communication between services and teams and there were opportunities for them to contact referrers for advice, support and clarification.

Staff worked closely with referrers to enable patients to have a prompt diagnosis.

## Seven-day services

**Appointments were flexible to meet the needs of patients, and appointments were available at short notice.**

As the service did not provide emergency scanning, it did not provide a seven-day service. However, there was flexibility within each list to accommodate patients requiring an urgent scan.

The service was open Monday to Friday from 8am to 8pm.

The department did not offer an on-call service, but opening hours could be altered to accommodate clinical emergencies.

## Health promotion

The provider did not have health promotion information available to support national priorities to improve the populations health. For example: smoking cessation, alcohol awareness and bone health.

Information on diagnostic procedures was available on the centre's website. Leaflets were provided to patients on what the scan would entail and what was expected of them prior to a scan. The centre also provided information to patients on self-care following a scan.

## Consent and Mental Capacity Act

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**

All staff understood the requirements of the Mental Capacity Act 2005. Mental Capacity Act (MCA) 2005 training was completed as part of the mandatory safeguarding vulnerable adults training. At the time of our inspection, all staff had completed this.

Patients were provided with information prior to their appointments and were given opportunities to ask questions when they arrived. This ensured their consent was informed.

Where a patient lacked the mental capacity to give consent, guidance was available to staff through the corporate consent policy.

Staff we spoke with understood the need for consent and gave patients the option of withdrawing consent and

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stopping their scan at any time. The service used consent forms that all patients were required to sign at the time of booking in at the service. There was a separate consent form available to use for patients with impaired capacity.

During this inspection there were no patients that lacked the capacity to make decisions in relation to consenting to their scan.

Staff were aware of children's consent procedures and the service had a consent policy in place. Young people (aged 16 or 17) were presumed to have sufficient capacity to decide on their own medical treatment, and provide consent to treatment, unless there was significant evidence to suggest otherwise. Staff were able to tell us about Gillick competence, this is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

### Are diagnostic imaging services caring?

Good 

We rated it as **good**.

#### Compassionate care

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

During this inspection we saw all staff treating patients with dignity, kindness, compassion, courtesy and respect. Staff introduced themselves prior to the start of a patient's treatment, interacted well with patients and included patients in general conversation.

In the interactions we saw during this inspection and feedback provided by patients we spoke with, staff demonstrated a kind and caring attitude to patients. Staff explained their role and explained to patients what would happen next.

During this inspection we spoke with four patients about various aspects of the care they received at Harley Street Medical Centre. Without exception, feedback was consistently positive about staff and the care they delivered.

Staff ensured that patients' privacy and dignity was maintained during their time in the centre and during scanning. Patients had designated changing rooms and were provided with a gown if required in the changing room to protect their modesty whilst having their scan.

To ensure patients were comfortable staff asked patients if they wanted a blanket for warmth and comfort before the procedure and we observed staff checking if patients were comfortable during the procedure.

Patient satisfaction was formally measured through completion of the service's 'Friends and Family Test' (FFT) following their examination. At the time of inspection, the FFT response rate was 8%. The percentage of patients that were extremely likely or likely to recommend Harley Street Medical Centre to their friends or family was 98%. Staff told us negative comments were scrutinised for opportunities to drive improvement in the service which included changes to premises, staff training or patient information.

#### Emotional support

**Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**

Staff supported people through their scans, ensuring they were well informed and knew what to expect.

Staff provided reassurance and support for nervous, anxious, and claustrophobic patients. They demonstrated a calm and reassuring attitude so as not to increase patients' anxiety.

We observed the staff provided ongoing reassurance throughout the scan, they updated the patient on how long they had been in the scanner and how long was left. Patients also had a panic button they could press any time during the scan to summon help. Staff could stop the scanning immediately if the patient requested this.

The centre's staff felt that recognising and providing emotional support to patients was an integral part of the work they did. Staff recognised that scan-related anxiety could impact on a patient's scan and this could result in possible delays with the patient's treatment.

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The centre had an up to date chaperone policy. Patients were asked at the time of booking if a chaperone was required. Chaperone information signage was displayed in all areas within the centre.

Family members or carers were able to accompany patients that required support into the scanning area.

Patients could request their own choice of music to listen to during the scan which was played through headphones. The centre had the facility to play any requested music, podcast or radio. This helped to disguise the noise the scanners made which could cause anxiety for some patients. Earplugs were also available which protected their ears and helped to reduce the noise.

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

### Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

We observed when staff checked through the patient's safety questionnaire, patients were given an opportunity to ask questions.

The service allowed for a parent or family member or carer to remain with the patient for their scan if this was necessary.

Staff recognised when patients or relatives and carers needed additional support to help them understand and be involved in their care and treatment. Staff enabled them to access this, including access to interpreting and translation services.

Patients and relatives and carers could ask questions about their scan. Patients could access information on any diagnostic procedure from the company's website. However, there was a wide range of information available to patients in the centre.

Patients were informed of when they would receive their scan results; there were clear expectations and the service met their timely goals.

We saw staff offering an explanation on aftercare to a patient. Staff told us all patients were provided with aftercare advice following a scan.

On inspection we did not see information available in a child friendly format to help children and young people make decisions about or agree to care and treatment.

## Are diagnostic imaging services responsive?

Good 

We rated it as **good**.

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

#### The service planned and provided care in a way that met the needs of local people and the communities served.

The premises were appropriate for the services delivered. All floors were accessible for wheelchair users.

Patients reported to a large, comfortable waiting area, where refreshments and toilets were available.

The corporate website provided useful information about the service, including downloadable safety questionnaires for patients to complete before their appointment.

Signage throughout the centre was clear, visible, and easy to follow. Patients were given information on how to find the centre and parking arrangements at the time of booking.

The service was located near established routes, with a bus stop and a train station a short distance away.

All patients were informed of when and how they could expect to receive the results from their scans.

The centre did not have a separate waiting or play area for children and young people using the service.

### Meeting people's individual needs

#### The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

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The administration team had initial contact with patients presenting to book a scan either face to face or on the telephone. It was at this point that an initial assessment of each patients' requirements were made.

Prior to any booking, a safety questionnaire and consent form were completed by the patient. For any patients who may have difficulties in completing this form steps were put in place to assist their needs. For example, copies of the safety screening forms were available in large font for patients with impaired vision and interpreters were available for patients that do not speak English as their first language.

Staff told us that relatives were not used as interpreters, to avoid any issues with consent. However, on inspection, we saw a family member translating for a patient during the consent process and procedure.

A chaperone service was available at a patient's request throughout their visit to the service and including accompanying them during procedures. Patients were also permitted to take a friend or relative into the scanning rooms with them if required.

The service was fully accessible to disabled attendees. There was a passenger lift servicing all floors and several chair lifts for sub landings.

There was an MRI compatible wheel chair available for patients unable to walk from the waiting area to the MRI scanner.

Hearing loops were accessible to patients throughout the service.

All aspects of patient requirements were considered before booking an appointment, for example, patients with reduced mobility would be allocated a longer scan appointment time.

Patients' wishes were always respected. If a patient requested attendance by a female radiographer, this would be accommodated. They had an equality and diversity policy, which all staff had read. Training had also been provided and completed.

There was provision of private changing areas within proximity to the scanner. Segregation of male and female patients was observed as far as reasonably practicable, and certainly if a need had been specifically mentioned.

There was a prayer room, available upon request. Patient information leaflets were available for all types of scans in the reception area and would also be sent to the patient before their scan.

Nervous, anxious, or claustrophobic patients were invited to have a tour of the unit prior to their appointment so they could familiarise themselves with the room and the scanner. The centre had a premium subscription to a digital music streaming service that gave access to millions of songs and podcasts from artists all over the world. Patients were able to listen to any music of their choice during their procedure.

Staff told us that they rarely saw patient's with complex needs. However, they would be given appointments to suit their needs and extra time slots. They also encouraged carers to be present.

## Access and flow

**People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.**

Patients were referred to the service by the local hospitals, GPs and through private referrals.

The service had a detailed plan for administration staff to follow when booking patient scans. The service had different time slots for different scans required.

When a valid referral was received, the patient was asked to complete a safety screening and consent form. Scans were allocated to a consultant radiologist depending on the speciality. The radiologist will justify and protocol the request and will create the report post scan.

An appointment was scheduled in discussion with the patient. It was normally possible to accommodate a time and date to suit the patient's requirements. Core scanning hours were often adjusted to accommodate urgent scans; staff worked flexibly and were prepared to reallocate breaks and often worked later than scheduled if required. Patients were never turned away due to lack of availability. The time from the scan to the report being available for the patient was within 48 hours.

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The service did not cancel patient appointments unless the situation was unavoidable. They also aimed to reschedule appointments unless on patients request.

On arrival at reception, patient details were checked and were handed across to the clinical team. The team introduced themselves to patients, friends and family using their first name and would ask the patient how they would like to be addressed.

Patients were informed by the signage at reception they could bring a friend or relative along for emotional support during their scan, or a chaperone could be provided. For friends and or relatives staying in the waiting room, staff would provide an estimation of the scanning time, as MRIs can be time consuming. Any delays during the scan were communicated to waiting relatives, to alleviate concern.

There was a process in place to ensure patients who did not attend (DNA) appointments were followed up. There had been two DNA in the last 12 months. They were rescheduled for another date and did attend.

From May 2018 to May 2019 the service reported eight cancelled procedures or examinations. The reasons for these were due to MRI technical faults. These were all rescheduled in a timely manner.

## Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**

The service treated concerns and complaints seriously, investigated them and shared any learning with staff. The Director of Clinical Services had overall responsibility for overseeing the management of complaints at the location.

United Medical Enterprises (UME) had a complaints policy in place, which outlined the process for recording and investigating complaints.

The staff we spoke with were aware of the complaints process and policy and where possible, they tried to resolve informal complaints immediately before they developed into more significant complaints.

The Director of Clinical Services was based in the facility and was available to ensure that patients were satisfied with all aspects of their visit to the centre. The front of house team with the support of the front of house manager spoke with patients, relatives and carers when delays occurred to avoid potential complaints. Most issues were dealt with informally at the time and were resolved before they escalated to becoming a formal complaint

Feedback from patients was sought through the patient satisfaction survey (PSS). The PSS circulated was anonymous, but if a concern was raised and contact details were supplied, the Director of Clinical Services would call patients to address the issue.

Data supplied by the centre ahead of the inspection stated there had been 20 complaints from May 2018 to May 2019. Of these, 14 were handled under the formal complaints procedure and all were upheld.

Informal complaints were escalated to the Director of Clinical Services who met with the patients at time of complaint to try and resolve the issues raised.

The centre had a complaints policy which all staff read and understood the process involved in the management of complaints.

Complaints leaflets were available at reception. These leaflets invite comments, concerns, complaints to be raised with the Director of Clinical Services.

Formal complaints were acknowledged within 48 hours of receipt with expectation that all formal complaints would be closed within 20 working days as per policy. Thereafter, a formal response would be provided to the complainant.

Formal complaints were invited in writing; to include date, appointment type, any staff involved and the specifics of the complaint. The complaint would initially be investigated and dealt with by the UME director of clinical service and the complainant would be addressed within 20 days. This was referred to as stage one in the complaints process. The leaflet reiterated that occasionally this timescale may be unrealistic but did state that the reasons for any delays will be disclosed.

If the problem was not resolved at initial stage, an appeal to UME managing director would be raised; This is referred to as stage two in the complaints process where

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an objective assessment of the complaint would be completed. If the complaint cannot be resolved to a satisfactory conclusion, an independent external adjudication would be performed. This was referred to a stage three

The Centre had a complaints tracker which was maintained by the executive assistance with support from the Director of Clinical Services.

All incidents, concerns and complaints were logged on the incident reporting system (Datix). Staff were actively encouraged to report near misses as valuable lessons could be learnt in preventing future recurrences.

All complaints, related trends and shared learning were discussed at the integrated governance committee and published within the integrated governance report on a quarterly basis. This was also escalated to the MAC and Board of Directors.

Complaints data and shared learning reports were published and displayed on the staff notice board on a monthly basis.

## Are diagnostic imaging services well-led?

Good 

We rated it as **good**.

### Leadership

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

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

The service was led by the Director of Clinical Services who acted as clinical and operational manager. The registered manager was supported by the executive management team and central support function.

The Director of Clinical Services reported directly to the managing director. The Director of Clinical Services had

weekly 1-2-1 meetings with the managing director. The executive team also met on a weekly basis to discuss the performance and challenges met by the service to ensure continuous improvements.

Leaders had the skills, knowledge, experience, and integrity they needed to ensure the service met patient needs. The management team described how they strived to be professional, open and inclusive.

Staff told us management were approachable and could raise any concerns they had. We observed friendly and professional interactions between management and staff.

Staff were clear about their role and who they reported to. Staff said leaders were very visible in the service.

Staff spoke highly of all levels of leaders including the executive manage

### Vision and strategy

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

The United Medical Enterprises Group had a clear vision and was promoting the best patient experience underpinned with strong clinical expertise.

The service had a clear vision driven by quality of care and safety for all patients. The service's vision and values were published and on view for all patients, staff and consultants who attend the centre.

The staff we spoke with could articulate the service's values and reported that they felt they reflected how they worked and delivered care. The values were displayed within the unit. Which were:

- Quality and the continual improvement of every aspect of our business to improve service, efficiency and effectiveness.
- Respect and compassion in the delivery of humane clinical services to patients and their families.

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- Customer-driven by striving to provide service of superior value to both internal and external customers, particularly through the optimum application of technology.
- Success-driven by learning from everything we do so that the results of our actions bring added value to our customers and the company.
- Teamwork is the means by which we achieve our success recognising that a good and motivated team is stronger and more effective than any individual.
- Integrity and honesty are demanded to engender trust within and outside the organisation and must underscore every action.
- Reward and recognition through all appropriate means to attract, retain and motivate staff.

## Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**

Staff told us they felt supported, respected and valued by the organisation. Staff told us they felt proud to work for the organisation. All staff we spoke with were very happy in their role and stated the service was a good place to work. All staff talked about the very supportive staff team.

The service's culture was centred on the needs and experience of patients. This attitude was reflected in staff we spoke with on inspection.

We spoke with nine members of staff at the centre. All staff spoke positively about the culture of the service and described it as a "great place to work". One staff member said, "I would have my family member or loved one treated here".

Staff worked closely with the consultant radiologists, who frequently attended during scanning, offering support and advice on additional sequences that may improve diagnosis on case by case basis. The radiologists were approachable and made themselves available; all staff felt comfortable discussing patients' treatment (protocols, contrast administration etc.) with the radiologists and challenging them if needed.

The service promoted equality and diversity, it was part of mandatory training, inclusive, non-discriminatory practices were promoted.

All independent healthcare organisations with NHS contracts worth £200,000 or more are contractually obliged to take part in the Workforce Race Equality Standard (WRES). Providers must collect, report, monitor and publish their WRES data and act where needed to improve their workforce race equality. The centre did not have any specific NHS contracts to the value of £200,000 therefore a report was not required.

There was a system in place to ensure non-NHS-funded people using the service were provided with a statement that included terms and conditions of the services being provided to the person and the amount and method of payment of fees.

## Governance

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

The centre had a clear governance structure. The centre had quarterly integrated governance meetings which were attended by senior representatives within clinical aspects of the business. It was also attended by external advisors to the business including the Radiation Protection Advisor (RPA), health and safety and infection control advisors. There were regular agenda items discussed including incidents, safeguarding, complaints, audits, shared learning, and practicing privileges update from the Medical Advisory Committee (MAC).

The centres governance structure was managed by the Director of Clinical Services who is the CQC registered manager. The governance structure gave assurance the centre operated within all aspect of regulatory compliance relating to service provided within the centre, including the CQC standards of care.

The centre had relevant committees and meetings where the vision and strategy were discussed and referred to. Quality improvement was part of everyday practice.

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The centre manager produced a quarterly integrated governance report in line with UME governance requirements. This included specific details on activity and variance over the quarter, complaints, incident reporting, MHRA (medicines and healthcare products regulatory agency) alerts and actions taken, audits and outcomes, health and safety reporting, radiation protection reports, and infection control reports.

At a local level, staff were updated on performance, complaints, incidents, policies, patient feedback and clinical issues through staff meetings.

On inspection, we saw a dedicated staff notice board available to all staff in the staff rest room. Key information was displayed. This included details of the safeguarding process, Caldecott guardian arrangements and responsibilities, monthly Datix, PSS and complaints reports and monthly audits completed and outcomes. The board also shared updates on infection control, health and safety and medicines management to ensure all staff were aware.

All staff personnel files were managed by the corporate human resources (HR) department. Local managers held files on staff development, such as appraisals, continuous professional development, local competencies, and training data.

## Managing risks, issues and performance

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**

The centre had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

There were both internal and external audits conducted to monitor the quality of services.

The centre had processes to identify, understand, monitor and address current and future risks. On inspection we saw an up to date risk register. All risks were reviewed and updated monthly. The risk register was last reviewed in May 2019 and was due for review in

June 2019. The highest risk on the register was, the use of temporary staffing solutions. This had mitigating actions in place, with permanent staff covering annual leave to eliminate the use of agency.

There was a radiation protection committee held annually. The service had a service level agreement with Kings College London for radiation protection advisory services, which included access to advice and support 24 hours a day, seven days a week. It also included inspections and audits and support with IRMER regulations and documentation requirements.

The centre had a comprehensive business continuity plan detailing mitigation plans in the event of unexpected staff shortages or scanner breakdown.

## Managing information

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

Electronic patient records were kept secure to prevent unauthorised access to data, however authorised staff demonstrated they could be easily accessed when required.

There were enough computers available to enable staff to access the system when they needed.

Staff were able to locate and access relevant and key records easily, this enabled them to carry out their day to day roles.

Staff had access to all relevant corporate and local documents within the unit and were also able to access elements of information securely from their own computers at home. This included electronic mandatory training.

Patient data was stored securely and not available to the public. A privacy filter was used on reception computer and staff locked computer screens when away from their desk. All computers were password protected. Passwords were changed regularly after an automated prompt.

# Diagnostic imaging

Information from scans could be reviewed remotely by authorised referrers to give timely advice and interpretation of results to determine appropriate patient care.

Scan referrals, registration forms, protocol forms and reports were scanned into individual patient folder within an electronic system. Original paper documents were kept for a minimal amount of time, being locked away until the final scan report had been generated. When all documents had been saved electronically, paper copies were securely shredded.

The department worked within General Data Protection (GDPR) regulations. Reports were securely emailed out to referrers using encryption. Any patient sensitive documents such as CDs were posted via recorded delivery.

Arrangements for advertising and promotional events seen on the centre's website, were in accordance with advertising legislation and professional guidance.

## Engagement

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

Patients were provided with satisfaction surveys to complete on line after attending the service. Patients could also complete a paper satisfaction survey whilst on site on quality of care and service provided and any suggestions for improvements they would advocate. The survey was reviewed monthly by the centre manager. Focus was made on the friends and family test.

The service actively published these results and considered all suggestions from patients. Patient surveys were anonymous; however, the centre manager did engage with patients that have provided contact details. Various communication methods were utilised; email, telephone and a posted letter were all available. The centre manager met with patients to discuss their suggestions if required.

A staff survey was introduced in 2018. This was planned to be repeated in the second quarter of 2019. This was a key opportunity for staff to share thoughts and opinions anonymously as an improvement tool. Results and associated action plans were shared with staff.

Improvements to the centre were made following direct patient or staff feedback. For example, cannulation competencies were updated with the imaging team following feedback whereby a patient had a difficult experience in CT, the process caused distress and pain to the patient. The feedback and action taken was followed up with the patient to give assurance that the centre had acted on their direct feedback.

## Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**

The management team were proactively improving care for patients using the service.

A key innovation programme was underway to make the service more accessible to patients and consultants using technology.

In 2018 the patient record system at the centre was changed. This change allowed the patient to access the 'self-service' online, giving access to the services 24 hours a day, seven days a week, enabling self-registration, appointment booking and secure access to their own medical records. This was set to be rolled out imminently at their sister location.

Consultant users had a secure referral portal, which allowed real time access to images and reports. This improved reporting times and offered a more secure method of communication with service users.

In quarter four of 2018 electronic patient satisfaction surveys were introduced, this increased response rates significantly but there was still an option at the centre for paper-based responses.

## Diagnostic imaging

For self-pay patients and any patients that needed to pay the centre directly an online payment portal was launched through the centre's website. This allowed greater accessibility to the service by giving patients 24/7 access.

The centre had a substantial investment from UME for a new facility in Harley street and were purchasing new and advanced technology to speed up MRI acquisition up to 50% and had capability for an auto attendant with 26 different languages which would help the diverse patient groups.

There would also be investment into CT and new technology which would significantly reduce exposure and contrast levels whilst providing higher quality imaging.

The centre was looking into online governance systems to become a paperless facility in 2020 as they move to a new location.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider **SHOULD** take to improve

- The provider should ensure there are adequate children friendly waiting areas within the centre.
- The provider should ensure there is a child friendly complaints process.
- The provider should continue to ensure all staff are aware of the local policy defining responsibilities and process for checking stock.
- The provider should ensure translation services are always used in place of patient's relatives or friends.
- The provider should continue to ensure staff undertake chaperone training as part of safeguarding training and arrange additional face to face chaperone training for all staff.