European Scanning Centre (Harley Street) Limited

European Scanning Centre

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this location improved. We rated it as good because:

- The centre had enough staff to care for patients and keep them safe.
- The centre provided mandatory training in key skills to all staff.
- Staff understood how to protect patients from abuse, were trained on how to recognise and report abuse, and they knew how to apply it.
- The centre had suitable premises and equipment and looked after them well.
- Staff completed and updated risk assessments for each patient and kept detailed records of patients' care and treatment.
- Staff provided kind and compassionate care to patients. Staff worked well together for the benefit of patients. Staff supported patients to make decisions about their care.
- Staff respected patients' privacy and dignity, took account of their individual needs, and helped them understand their conditions.
- Patients could access the service when they needed it and did not have long waits for diagnostic imaging procedures.
- Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on the company's shared values. Staff felt respected, supported and valued and were focused on the needs of patients.

However,

- The service did not manage patients' medicines well. The medicines management policy did not detail adverse effects and double checking of glycerine trinitrate (GTN), or the procedures for the administration of patient specific drugs (PSD). The service did not have a system of regular medicines administration audits. PSD drug administration lists were not fully completed and clear about patients prescribed medicines.
- Disclosure and Barring Service (DBS) certificates were not always in accordance with the provider's policy.
- Some of the centre's policies had not been reviewed in accordance with the published review date.
- There was a lack of clarity on whether European Scanning Centre or Alliance Medical UK Limited (AML) were responsible for shared risks on the risk register.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Good 	Our rating of this service improved. We rated it as good because: • Staff engaged in clinical audit to evaluate the quality of care they provided. • Managers ensured staff received training, supervision and appraisal. • Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. • Staff had access to the full range of specialists required to meet the needs of patients. • Managers monitored the effectiveness of the service and staff worked well together for the benefit of patients. • Facilities and premises were appropriate for the services being delivered. • Staff worked well together as a multidisciplinary team. • Staff understood and discharged their roles and responsibilities under the Ionising Radiation Medical Exposure Regulations (IRMER). However, we also found: • The medicines management policy did not detail adverse effects and double checking of glycerine trinitrate (GTN), or the procedures for the administration of patient specific drugs (PSD). The service did not have a system of regular medicines administration audits. PSD drug administration lists were not fully completed and clear about patients prescribed medicines. • Staff Disclosure and Barring Service (DBS) certificates were not all held in accordance with the provider's policy. • Bank and agency staff were provided with printed copies of policies and procedures. There was a risk that staff may not have the most up to date versions of policies and procedures.

Summary of findings

There was a lack of clarity whether European Scanning Centre Limited or Alliance Medical Limited (AML) owned and were responsible for shared risks on the risk register.

Summary of findings

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Summary of this inspection

Background to European Scanning Centre

The European Scanning Centre is a private diagnostic imaging service operated by European Scanning Centre (Harley Street) Limited. The service opened at its current location in December 2009. European Scanning Centre is a private diagnostic imaging service and primarily services the communities of Greater London (with some national and international referrals).

The service is owned and operated by European Scanning Centre (Harley Street) Limited, the registered provider with CQC. European Scanning Centre (Harley Street) Limited is a wholly owned subsidiary of Alliance Medical Limited (AML). AML registered with the CQC in July 2015.

At the time of inspection, the service had a new centre manager who was responsible for running the service on a day-to-day basis. They were supported by a range of clinical staff including radiologists and radiographers. The centre manager was in the process of applying for registration with the CQC as the registered manager.

European Scanning Centre were leaseholders for the building at 68 Harley Street, London, W1G 7HE. The clinical areas in the centre are split over three floors, (basement, ground and first floor). The basement houses the computerised tomography (CT) scanner and magnetic resonance imaging (MRI) open scanner. The ground floor housed the EOS scanner. The centre provides a range of diagnostic and screening procedures including: cardiac, lung disease, gastrointestinal, musculoskeletal, osteoporosis, neurological, and gynaecological. The service occasionally provides scoliosis scans for children and young people, (scoliosis is a sideways curvature of the spine that most often is diagnosed in adolescents).

The service also provides services for private patients and patients referred from the NHS through clinical commissioning groups (CCG) or GPs.

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury
- Surgical procedures

The service is open Monday to Friday from 8am to 8pm. Appointment times for MRI are generally held between 8am to 6pm. Patients are seen by appointment only. The service provided CT on alternate Saturdays between 8am and 6pm.

The service was last inspected in 2019 and was rated requires improvement.

How we carried out this inspection

The team that inspected the service comprised a CQC lead inspector and diagnostic and screening specialist advisor. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

We inspected the European Scanning Centre on 25 February 2022 using our comprehensive inspection methodology. This was an unannounced inspection.

Summary of this inspection

During the inspection visit, the inspection team: looked at the quality of the scanning environment and observed how staff were caring for patients, spoke with the centre manager, spoke with seven other members of staff including a radiographer, administrative staff, spoke with five patients who were using the service, reviewed seven patient care and treatment records, looked at a range of policies, procedures and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure there is a medicines management policy that details the adverse effects and double checking of glycerine trinitrate (GTN) prior to administration. The policy should clearly set out procedures for the administration of patient specific drugs (PSD). (Regulation 12)
- The service must ensure there is a system of regular medicines administration audits which includes checks on the correct completion of PSD administration forms. (Regulation 12)
- The service must ensure PSD drug administration lists are completed accurately and the information on patients prescribed medicines is clear. (Regulation 12)

Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The service should clarify whether European Scanning Centre or AML own and are responsible for shared risks on the risk register.
- The service should ensure all staff Disclosure and Barring Service (DBS) certificates are held accordance with the provider's policy.
- The service should ensure policies are reviewed in accordance with their review date.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic and screening services	Requires Improvement	Good	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Good	Good	Good

Good

Diagnostic and screening services

Safe	Requires Improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are Diagnostic and screening services safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

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

Staff received and kept up to date with their mandatory training. Data provided by the service following the inspection showed 91% of staff were compliant with mandatory training.

Mandatory training was comprehensive and met the needs of patients and staff. Some bank staff and staff with practising privileges completed mandatory training with their main employer. Consultants and bank staff that completed mandatory training with other employers were required to share the documentary evidence of completion with the centre.

Compliance with mandatory training was monitored by the centre manager and the Alliance Medical Limited (AML) learning and development team.

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.

Staff received training specific for their role on how to recognise and report abuse. Data provided by the service following the inspection showed 94% of staff had completed mandatory safeguarding training in adults safeguarding, this was better than the provider's minimum standard of 90%. Furthermore, 94% of staff completed level 2 safeguarding training in children's safeguarding, this was better than the provider's minimum standard of 90%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were trained to recognise adults and children at risk and were supported by the European Scanning Centre's safeguarding policy.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The centre manager was aware of how to report safeguarding concerns to the local authority safeguarding team. The service had not reported any safeguarding incidents in the previous 12 months.

Staff followed safe procedures for children visiting the service /department. For example. safeguarding training included child sexual exploitation (CSE) and female genital mutilation (FGM). Support with safeguarding concerns was provided to staff by the Alliance Medical Limited (AML) level 4 trained safeguarding lead.

Team meeting minutes demonstrated that safeguarding was discussed at the centre's team meetings.

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness. The centre had annual quality assurance reviews (QAR) from the provider. A review had taken place a month prior to the inspection. The QAR report, dated January 2022, showed in the previous 12 months, the centre had 87% compliance with the provider's infection prevention and control procedures (IPC). This was worse than the provider's 95% minimum standard, but an improvement from the previous score of 73%. In response, the provider had produced an action plan, which was monitored to completion by the centre manager and the provider's senior management team.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The radiographer staff were responsible for ensuring the magnetic resonance imaging (MRI) examination room was cleaned daily to ensure safety precautions for magnetic scanners were observed. The infection prevention and audit dated January 2022 for the MRI, computerized tomography (CT) and EOS scanners demonstrated 100% compliance with the audit outcomes.

Staff followed infection control principles including the use of personal protective equipment (PPE), and were guided by relevant policies. Clinical staff wore scrubs and were bare below the elbows.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Hand hygiene audits for January 2022 and February 2022 recorded 100% compliance with hand hygiene practice.

The service had an up-to-date infection prevention control policy which was approved for use on 26 January 2021. The policy provided staff with clear guidance on the AML framework of required actions to ensure a safe and clean environment for patients, staff and visitors.

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.

Good

Diagnostic and screening services

The service had enough suitable equipment to help them to safely care for patients. During a previous inspection on 17 June 2019, we found the room behind the generator storeroom was cluttered with items subject to the control of substances hazardous to health (COSHH) regulations 2002. However, during this inspection we found this had been addressed and the area was tidy. Furthermore, the centre had installed clearly labelled lockable cupboards for the storage of hazardous substances.

Patients could reach alarms and staff responded quickly when called. Patients were provided with an alarm during their scan and could use this to alert staff if they were experiencing discomfort during their procedure. All equipment was equipped with microphones and speakers to enable patients and staff to communicate throughout the scanning procedure. Staff could stop scanning procedures immediately if a patient requested this.

The design of the environment followed national guidance. Scanning rooms were fitted with oxygen monitors, in accordance with Medicines and Healthcare products Regulatory Agency (MHRA) guidance, 5.4.6, to ensure any helium gas leaking (quench) from the cryogenic dewar could not leak into the scanning room, (a cryogenic dewar is a specialised type of vacuum flask used for storing cryogens (such as liquid helium), whose boiling points are much lower than room temperature).

Staff carried out daily safety checks of specialist equipment. All scanners had a schedule of preventative maintenance every three months. The provider had an in-house quality assurance programme that included all essential tests in accordance with IPEM 91, 'recommended standards for the routine performance testing of x-ray imaging systems, 2005'.

Rooms where ionising radiation exposures occurred were signposted clearly with warning lights; access to the rooms was restricted when a scan was in progress.

The fringe field around the magnetic resonance imaging (MRI) scanner was displayed clearly. (This zone is the peripheral magnetic field outside of the scanners magnet core. It is important because it can cause interference with nearby electronic devices, such as pacemakers).

The MRI and computerized tomography (CT) scanners were equipped with a phantom scanner. These are specially designed objects that are scanned or imaged in the field of medical imaging to evaluate, analyse, and tune the performance of various imaging devices.

All equipment in the MRI room was labelled in accordance with recommendations from the Medicines and Healthcare products Regulatory Agency (MHRA). For example, 'MR Safe', 'MR Unsafe', 'MR Conditional', 'MR Safe.'

Access to the MRI room was controlled, with signage on doors explaining the magnet strength and safety rules.

Radiation badges, (these are devices containing a radiation-sensitive crystal that monitors the radiation levels an individual is exposed to), were located in scanning areas were returned and sent for reading monthly.

Sharps disposal bins, (these are secure boxes for disposing of used needles), were located appropriately across the service. We saw sharps bins were clean and not overfilled. Labels had been completed correctly, signed and dated to inform staff when the bin had been opened.

The service had suitable facilities to meet the needs of patients' families. The service had local rules (IRR) for diagnostic and screening equipment in controlled areas, as well as employer's procedures in place (IR(ME)R) which protected staff and patients from the risks associated with ionising radiation.

The service had an up-to-date fire evacuation plan. The service completed a fire risk assessment annually and there was an action plan in place. Staff undertook fire safety as part of their mandatory training. On 16 March 2021 the compliance rate for fire safety training was 95%.

Staff disposed of clinical waste safely. Clinical and domestic waste bags were segregated and clearly marked for clinical or domestic purposes. The service had a service level agreement (SLA) in place for the safe disposal of clinical waste.

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

Staff could respond promptly to any sudden deterioration in a patient's health. Equipment used in the management of patients in a medical emergency was regularly tested, and these were up to date. The centre had a defibrillator. The centre's resuscitation 'grab bags' were stored in rooms where scanning took place, equipment had been checked daily by staff and records were up to date.

The centre conducted an annual medical emergency simulation, to assess the safety of the service provided. This was facilitated by an AML quality assurance assessor. Feedback from the simulation was provided to staff for their learning.

All staff were trained in basic life support. The mandatory training spreadsheet dated 16 March 2022 recorded 100% of staff had up to date training in basic life support. Paediatric immediate life support (PILS) trained staff were factored into the staffing rota when a child had a scanning appointment. In the event of a medical emergency, staff would provide basic life support, and would call 999.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. For example, the service used an MRI patient safety questionnaire.

Patients were risk assessed including checks for metallic foreign bodies, such as pacemakers. Risk assessments included allergies and past medical history. Risk assessments were reviewed by clinicians when patients arrived for appointments.

Staff knew about and dealt with any specific risk issues. The centre had signage highlighting contra-indications, (a contra-indication is a condition that serves as a reason not to perform a certain medical treatment due to the harm that it would cause the patient). Patients reporting contra-indications would not be scanned and would be referred to the referring clinician.

The service ensured that females, who were or may be pregnant, always informed a member of staff before they were exposed to radiation in accordance with the Ionising Radiation Medical Exposure Regulations (IRMER).

Staffing

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

The service had enough staff to keep patients safe. The provider had conducted a staffing needs assessment for the centre. The staffing needs assessment was based upon patient needs, clinic opening hours, expected activities, and staff training requirements.

Good

Diagnostic and screening services

Managers accurately calculated and reviewed the number and grade of staff needed for each shift in accordance with national guidance.

The manager could adjust staffing levels daily according to the needs of patients. Staffing levels were reviewed in advance by the centre manager to ensure an adequate number of clinically trained staff were available. Clinical activity did not take place unless minimum staffing levels were met.

The number of staff matched the planned numbers. The centre's staff worked across two European Scanning Centres in London. The provider had 11 radiographers that worked flexibly across both sites, four clinical assistants that flexed across sites, a medical secretary that supported reporting on both sites, and 14 administrators working across both sites.

The service had low turnover rates. Five staff had left the service in the previous 12 months, these posts had been successfully recruited to.

The service had low sickness rates. The sickness rate in January 2022 was below the scheduled staffing needs for administrative staff. Managers told us this was due to COVID-19 having adversely affected a few administrative staff. However, other administrative staff had worked flexibly to provide staffing cover.

Radiologists worked under practising privileges. This helped the provider to check radiologists had the right qualifications, skills and experience to perform their roles. (A practising privilege is the 'licence' agreed between an individual medical professional and a private healthcare provider. They set out the range of procedures the clinician is permitted to perform). The service made sure all staff with practising privileges had valid professional registrations, medical indemnity insurance and had completed appraisals.

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.

Patient notes were detailed, and all staff could access them easily. The service had an electronic patient record system. Paper-based patient forms were scanned onto the patient records. Staff completing scans updated patients' electronic records and submitted the scanned images for reporting by a radiologist.

The provider's quality and risk assessor had undertaken a review of the centre's records in January 2022. The assessor found significant improvements since their previous visit in 2021. The review found the centre had 89% compliance with the provider's standards for records management. This was better than the provider's minimum compliance standard of 75%.

Records were stored securely. Clinical staff had password protected access to the picture archiving and communication system (PACS). (This is a medical imaging technology which provides storage and convenient access to images). This ensured only authorised staff had access to patient PACS information.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff did not always have systems and processes to prescribe and administer medicines safely. The centre's medicines management policy, dated January 2022, did not mention the checking and administration of patient specific drugs (PSD). Furthermore, the policy did not detail adverse effect or double checking of glycerine trinitrate (GTN) prior to administration, (this is a medicine used in acute angina).

Staff did not always complete medicines records accurately. During the inspection we viewed three PSD administration forms. One had not been signed by the prescribing radiologist; two forms had been signed by the radiologist but did not have the name of a patient or patient detail recorded on the form. Furthermore, administrators told us they stapled the PSD form to a referral form and gave the documents to the radiologist to sign and complete. However, there was a risk of the PSD forms becoming detached from the referral form, and patient information being lost or the patient not having a full identifiable patient record.

PSD records had a list of all medicines which could be administered. The medicines which were not applicable to the patient should have been crossed out on the PSD form. However, we found three PSD forms where the medicines had not been crossed out. This meant the PSD prescription indicated that all the medicines on the forms had been identified as suitable to be given to the patients.

Staff told us the service did not regularly audit drug administration, this meant the service could not be assured that medicines were administered in accordance with the provider's procedures.

Staff stored and managed all medicines and prescribing documents safely. Paper based records were stored in secure filing cabinets and scanned onto patients' electronic records.

Incidents

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

Staff knew what incidents to report and how to report them. All staff had access to the national electronic incident reporting system. Staff told us they were encouraged to report incidents.

Staff raised concerns and reported incidents and near misses in line with the service's policy. The Ionising Radiation (Medical Exposure) Regulations (IRMER) set out the responsibilities of duty holders (such as employers and referrers) for radiation protection. There were no IRMER/IRR reportable incidents reported in the 12 months prior to the inspection.

The service had no never events. There had been no incidents of patients having adverse reactions or side effects to their care and treatment in the previous 12 months.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. The centre had an 'incident management framework policy' and 'duty of candour' policy. All staff were required to sign these policies as evidence of having read them.

Staff received feedback from investigation of incidents, both internal and external to the service. Learning from incidents was shared with staff at team meetings and via a company risk newsletter, 'Risky Business.' This was emailed to all staff on a monthly basis.

Good

Diagnostic and screening services

There was evidence that changes had been made as a result of feedback. For example, following the inspection, the provider produced an action plan dated 28 February 2022. The action plan stated that an incident report had been completed regarding issues inspectors had found with patient specific drugs (PSD). As a result, an audit had been scheduled for 8 March 2022. The centre had introduced a new PSD procedure on 3 March 2022. This information was disseminated to staff at a team meeting on 3 March 2022.

Are Diagnostic and screening services effective?

Good

Our rating of effective stayed the same. We rated it as good.

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 followed policies to plan and deliver high quality care according to best practice and national guidance. However, during the inspection we found some policies had not been reviewed in accordance with their scheduled review date. For example, the AML 'Medical Emergencies Management Policy and Procedure, version 6', had a review date of 1 October 2021. This meant the provider could not be assured all policies were in date and reflected current best practice.

Staff followed safety guidelines from the Medicines and Healthcare products Regulatory Agency (MHRA), such as 'Magnetic resonance imaging (MRI) equipment in clinical use: safety guidelines', 2021.

We found MRI local safety rules were in place were in date and based upon best practice

guidance. These were based on safety guidelines from the MHRA, 2021.

The lead clinician had reviewed the centre's IRMER procedures and protocols in March 2021 to ensure protocols were up to date for all equipment.

Staff received a regular newsletter from the provider. This informed them of policies and procedures that had been updated and informed staff that they must read the policy and sign a form on the company's shared IT drive to confirm this.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. For example, we saw an annual audit report dated 14 April 2021 which was completed by the external medical physics expert. The audit was based centre's compliance with current ionising radiation regulations. The audit outcome was that service was compliant with the regulations.

Outcomes for patients were positive, consistent and met expectations, such as national standards.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. For example, an external contractor performed a regular audit on image reporting undertaken by the centre for both NHS and private patients. Results of these audits were shared with the clinician that referred the patient.

Managers used information from audits to improve care and treatment. The centre had a schedule of regular audits. Outcomes of audits were shared with staff at team meetings and actions to improve practice were addressed.

Improvement was checked and monitored by the provider. The provider's quality assurance report (QAR), January 2022, reported that a radiation protection supervisors audit had been completed in January 2022. The report found 'minor non-conformity' with the provider's audit outcomes. An action plan was in place to address this.

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. However, Disclosure and Barring Service (DBS) certificates held within staff files were not always in accordance with the provider's policy.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service had robust arrangements in place for granting and reviewing practising privileges.

Managers gave all new staff a full induction tailored to their role before they started work. During the inspection we viewed a corporate induction agenda dated 6 December 2021. This outlined the training staff would receive during the corporate induction day. Induction training included: infection prevention and control; governance; and incident reporting.

Managers supported staff to develop through yearly constructive appraisals of their work. For example, 100% of radiologists had submitted an annual appraisal from their main employer. The service ensured any changes in the tasks they performed for their main employer were replicated at the centre.

Managers supported staff to develop through regular, constructive clinical supervision of their work. Radiographers' performance was monitored by the Radiologists. Radiologists fed back any performance issues with scanning to radiographers, to enhance learning or highlight areas that could improve their performance.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Following team meetings, all staff were emailed presentations and minutes of the meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. All radiography staff were registered with the Health and Care Professions Council (HCPC). Staff were supported by the provider to meet the renewal requirements of their registration.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. The centre manager told us they were committed to staff development and were looking at ways staff could access further training. For example, a staff member was doing a course in British Sign Language (BSL).

Managers made sure staff received any specialist training for their role. Staff responsible for working with radiation were provided with training in the regulations, radiation risks, and use of radiation in accordance with the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017.

Good

Diagnostic and screening services

Multidisciplinary working

Staff worked together as a team to benefit patients. They supported each other to provide good care.

The service had effective relationships with other external partners, including completing scans for local NHS providers and private healthcare providers.

Staff communicated well with referring clinicians and could contact them for advice, support, and clarification as required.

The centre had a service level agreement (SLA) in place for the provision of blood testing services from a private laboratory. Staff told us the service worked well with the private laboratory in the relay of blood test results to patients and referring professionals.

The service had a contract with an external medical physics expert. This is a person providing clinical professional services, (a qualified medical physicist (QMP) is an individual who is competent to independently provide clinical professional services in medical physics). Staff told us the medical physicist was approachable and could provide advice on request.

Seven-day services

Key services were available to support timely patient care.

The service operated Monday to Friday, 8am to 8pm and operated bi-weekly Saturdays, 8am to 6pm.

Patient scanning appointments were flexible and could be offered at short notice if required. We spoke with a patient who told us they had been offered an appointment within 48 hours of their GP having referred them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. All staff received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) as part of mandatory safeguarding training. The provider's mandatory training spreadsheet recorded 94% compliance with the training.

Staff made sure patients consented to treatment based on all the information available. Staff said they would not make an appointment for a patient if there were concerns about their capacity to consent.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. During the inspection there were no patients attending the clinic that lacked the capacity to consent to procedures. Staff always encouraged vulnerable patients to be accompanied to their scans, if there were concerns about their ability to consent to procedures.

Staff clearly recorded consent in the patients' records. All patients were required to complete a safety questionnaire which the radiographer would sign and date. Staff gave patients the option of withdrawing consent and could request their scan to be stopped at any time during a scanning procedure.

Good

Diagnostic and screening services

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. The centre requested a written consent form from the referring clinician prior to making appointments for children.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. For example, staff had access to the provider's level 4 safeguarding lead who could provide advice and guidance on consent.

Staff could describe and knew how to access the policy on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were aware of the European Scanning Centre's consent policy, version 3. The policy detailed the centre's procedures regarding consent to care and treatment. However, we found the policy had a review date of 1 May 2021. This meant the policy had not been reviewed in accordance with the published review date.

Are Diagnostic and screening services caring?

Good

Our rating of caring stayed the same. 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.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff were courteous in their interactions with patients.

Patients said staff treated them well and with kindness. Patients gave positive feedback of their experience at the centre. For example, a patient told us, "The service has been 100%; we got a call yesterday and they said come in today. They've been very polite and very professional."

Patients had changing rooms and were provided with a gown and slippers, where required, to protect their modesty during scanning procedures. Patients could request: ear plugs; headphones; music; ambient lighting; and lockable storage for their personal items.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We saw the centre's chaperone policy was displayed in clinical areas. Patients were also asked at the time of booking an appointment if they required a chaperone.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients said they felt well supported during their scans. Patient said staff ensured they knew what to expect during a scanning procedure.

Good

Diagnostic and screening services

Patients could bring their own music to listen to during a scan and the centre provided earphones for this purpose. This helped to conceal the noise from scanners and reduce any anxiety patients may be experiencing during a procedure. The centre also provided earplugs to patients if they preferred not to have music during their scan.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff adopted an attitude of calm reassurance when patients were receiving scans. Staff provided support for claustrophobic patients and patients that were nervous or anxious about their scans.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients could be accompanied by a family member to support them during their scan.

Parents could accompany children whilst having a scan. Parents were risk assessed and provided with a lead rubber coat during procedures, these are shielding garments used to protect patients and workers from radiation during *diagnostic* imaging.

Staff talked with patients, families and carers in a way they could understand. Patients were informed what to wear to their scan. Contra-indications, including tattoos and piercings, were discussed with patients prior to their appointment. Staff gave patients information on preparing for a scan and what they should bring with them to their scan.

Patients or relatives and carers requiring additional support due to a language barrier had access to interpreting and translation services to help them understand and be involved in their care and treatment.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patient satisfaction was measured through completion of a patient satisfaction survey which was sent electronically following their scan. Anonymised responses were analysed by the administration manager for themes and trends. We viewed feedback on the centre's website and found this was consistently positive.

Are Diagnostic and screening services responsive?

Good

Our rating of responsive stayed the same. 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. It also worked with others in the wider system and local organisations to plan care.

Good

Diagnostic and screening services

Managers planned and organised services, so they met the changing needs of the local population. The service provided ultrasound, upright magnetic resonance imaging (MRI), computerized tomography (CT) scanning, and EOS scanning. Services were mainly provided for the population of Greater London. However, the service could provide scanning services for people from across the UK and international patients.

The centre provided scans for both private and NHS patients. The number of patient scans on behalf of insurance companies from the 1 February 2021 to 1 February 2022 was 3815. In the same period the number of patient scans on behalf of NHS was 812. The centre did not accept patient self-referrals.

Facilities and premises were appropriate for the services being delivered. European Scanning Centre were leaseholders for the building at 68 Harley Street, London, W1G 7HE. The centre sub-let part of the property to three other providers.

The clinical areas in the centre were split over three floors, (basement, ground and first floor).

The basement housed the computerised tomography (CT) scanner and magnetic resonance imaging MRI open scanner. The basement also housed patient changing room, a cannulation room and a toilet. The basement could be accessed via a stairlift or stairs.

The reception area on the ground floor was accessed via the main entrance. The ground floor had a patient waiting area, this was scheduled to be refurbished in the week following the inspection. The ground floor also housed offices, a blood testing room and the EOS scanner.

The service provided services for a range of patients, however patients with reduced mobility were referred to another London location, due to the centre not having a lift.

The service sometimes saw children for EOS, which was mainly for scoliosis, (EOS imaging is a low-dose, weight-bearing X-ray. It can simultaneously take full-body, frontal and side view images of a patient in a standing or sitting position, using significantly less radiation than traditional X-rays or CT scans).

Managers monitored and took action to minimise missed appointments. In the event of a patient not attending an appointment, the centre would call the patient and rearrange their scan, they would also record the patient as not attending their appointment.

Managers ensured that patients who did not attend appointments were contacted. Staff always contacted the referrer if a patient did not attend (DNA) the centre for a scan. The centre's key performance indicator (KPI) report indicated the DNA rate in January 2022 was 1%, this was better than the company's 4% standard.

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. They coordinated care with other services and providers.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Patients mobility needs were assessed at their initial assessment. The service did not have a lift. Patients were made aware that it would not be suitable for people using wheelchairs. Patients requiring wheelchair access, or patients unable to use a stairlift, would have their appointment booked at another of the provider's London centres.

The service had information leaflets available for non-English speaking patients. Patients requiring information in other languages and formats such as large print or Braille could receive translations of any of the provider's documents and leaflets upon request.

Managers made sure staff, patients, and carers could get help from interpreters or signers when needed. Interpreters could be booked in advance where required. Staff were aware of the process for booking interpreters.

Staff had access to communication aids to help patients become partners in their care and treatment. The centre was equipped with a hearing loop for patients with a hearing impairment.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times for treatment were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The centre did not have waiting lists. However, bulk bookings from NHS trusts had patient appointments based on the date of the patients follow up NHS appointments.

Scans were booked over the telephone or by email. The centre also had access to the NHS platform and received NHS referrals via the platform.

Managers worked to keep the number of cancelled appointments to a minimum. The service had 176 cancellations from 26 April 2021 to 27 January 2022, these were mostly due to scanner breakdown. The centre would always try and accommodate scans at another London scanning centre before they cancelled a patient's appointment.

Appointments usually ran to time. Reception staff were responsible for advising patients of any delays in clinic running times on their arrival at the centre.

When a patient attended the clinic for an appointment, they were asked to complete a registration form and a patient safety questionnaire. The reception team would inform the clinical team of the patient's arrival. Following their scan, the patient returned to the waiting area for 15 minutes to ensure they did not have any side effects from their scan.

Scan results were usually available within the stated turn-around times of 24 hours to 48 hours. The service provided reports to referring doctors within 48 hours of the scan. The reports were completed by the medical secretary. The service was meeting 100% of the scan to report within 48 hours of the scan having been completed.

The service had a six-week turnaround for scans performed for the NHS. The service was meeting 100% of the six-week turnaround appointments.

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.

Good

Diagnostic and screening services

The service clearly displayed information about how to raise a concern in patient areas. However, the service's complaints policy was not available on the European Scanning Centre website. The website had telephone numbers for each centre and an email address for appointments, but, did not have the complaints policy or a contact address for complaints.

Staff understood the policy on complaints and knew how to handle them. Complaints were a standard agenda item at team meetings. Staff told us complaints and patient feedback were always discussed at team meetings. We saw a team meeting presentation dated February 2022. This reviewed the centre's key performance (KPI) dashboard. The dashboard recorded there had been no complaints to the service in January to February 2022.

Managers shared feedback from complaints with staff at team meetings and learning was used to improve the service.

Are Diagnostic and screening services well-led?

Good

Our rating of well-led improved. We rated it as good.

Leadership

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

Leaders had the skills, knowledge, experience and integrity needed, both when they were appointed and on an ongoing basis. Alliance Medical UK Limited (AML) had acquired European Scanning Centre (Harley Street) Limited in 2019. The service was supported by the corporate structure of AML.

The AML managing director had overall responsibility for the strategic and operational management of the European Scanning Centre (Harley Street) Limited, including ensuring the organisation's procedures complied with all legal, statutory and good practice requirements. Heads of divisions had overall accountability for their speciality. The radiation protection advisor was responsible for the provision of specialist advice on radiation protection issues.

The provider had a local senior management team that had oversight of the two European Scanning Centre locations in London, including Harley Street. The senior management team consisted of two patient services managers, an administrative services manager, and the imaging services manager.

At the time of inspection, the service had a new centre manager. The new centre manager had previous experience of managing a service with regulatory responsibilities. They had transferred from a registered manager role at one of the provider's other locations in November 2021. The centre manager was in the process of applying to register as the registered manager with the CQC.

Staff said there had been a lot of changes in the management of the centre, and the new centre manager was positive and supportive. Staff also said the centre manager was driving improvements at the service and had insight into the regulatory requirements for health and social care.

Good

Diagnostic and screening services

The imaging manager was responsible for clinical staff across both London sites, including Harley Street. The administration manager was also responsible for administrative staff across both sites.

Managers had completed leadership training with a private provider of leadership and management courses. The imaging manager was completing a leadership course with an online academy.

AML provided radio pharmacy oversight via a director of radio pharmacy; the director had responsibility for the preparation of radiopharmaceuticals to ensure their safety, (radio pharmacy involves preparation of radioactive materials for patient administration that will be used to diagnose and treat specific diseases).

The provider had a contract with a radiation protection advisor, this is a person competent to advise employers on the safe and compliant use of Ionising Radiations. The post is a legally recognised position and is a requirement of the Ionising Radiations Regulations 2017 (IRR).

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.

Staff at the centre were aware of plans to develop the service. This included an action plan to ensure the service was compliant with AML key performance indicators (KPI) and strategic objectives.

Staff were aware of the AML values. Staff were aware that behaviours should be aligned to the AML values. Staff appraisals were linked to the AML vision and values.

The AML strategy was aligned to the company values. Each company value had a strategic objective, the strategy explained the objective, why this was strategically important, what the company wanted to achieve with their strategic approach, and how their strategic objective would be achieved.

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.

The centre was acquired by AML in 2019. The European Scanning Centre team was in transition. AML had assessed the centre and identified a gap in clinical organisation. The centre had an improvement plan, and this was monitored by AML. Staff said they were working on changes to the culture at the centre. Staff said there had been a cultural shift from a focus on the provision of private scanning services to a focus on the provision of scanning services for the NHS. This included new ways of working, for example, staff using NHS referral platforms.

Staff said they felt supported, respected and valued by the centre manager and provider. Staff said they felt proud to work for the provider. All staff we spoke with told us they were very happy in their role and said the centre was a good place to work. All staff reported the European Scanning Centre team as supportive.

The centre manager had arranged a 'Team building, wellbeing and training' day in February 2022. The key focus of the day was: governance, infection prevention and control, incident reporting and the provider's business objectives: as well as the provider's strategy and mission. The sessions were delivered by the AML quality and risk team and operational management team.

The culture of the centre was focused on the needs and experience of patients and was reflected in the staff attitude and behaviours. For example, the service had a patient experience manager, who had completed a training course on understanding patient experiences.

Staff told us they felt supported in their roles and would be able to challenge poor practice or raise concerns with the centre manager. AML had clearly defined management structures, however, it was unclear where European Scanning Centre (Harley Street) Limited sat within the AML management structure.

Equality and diversity training were mandatory for all staff. The mandatory training spreadsheet dated 16 March 2022 recorded 95% of staff had up to date training in equality and diversity.

The provider had a whistle blowing policy and a duty of candour policy to promote staff being open and honest. All staff were required to sign the policies to confirm having read them.

The provider had compiled a Workforce Race Equality Standard (WRES) report in October 2021. This met requirements for all NHS commissioners and NHS healthcare providers including independent organisations to have agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

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 AML medical director was responsible for identifying and ensuring implementation of all governance procedures.

The centre manager told us performance was regularly discussed at team meetings. Staff we spoke with were clear about their roles and understood the lines of accountability. There was a clear process to ensure staff working with practising privileges were competent and held indemnity insurance.

Progress in the quality and safety of services was monitored by AML via key performance indicators (KPI) and performance dashboards. This enabled the company to monitor patient outcomes and risks at the centre. AML had undertaken a quality assurance assessment of the service in August 2021 and an action plan had been produced. This was monitored by the AML director of quality assurance and risk. At the time of the assessment the centre had achieved 90% compliance with the AML KPI.

We viewed the centre's quality assurance report (QAR) dashboard. This clearly identified areas for improvement and timescales for these to be implemented. The dashboard had a named senior governance manager who was responsible for monitoring each area of improvement. The dashboard was regularly updated with actions the centre had taken to meet the KPI. For example, the dashboard recorded that an audit of staff training on 11 January 2022 found two staff did not have up to date life support training. The dashboard recorded that the two members of staff had been booked on the earliest available refresher training, which would take place on the 4 March 2022.

The service had service level agreements (SLA) in place with third party providers of services. For example, we viewed an SLA dated 1 January 2022 for the provision of blood testing services.

Staff received a weekly newsletter from AML called 'Gatekeeper.' This newsletter provided a weekly update on operational performance. For example, the newsletter dated 7 March 2022 had information on medical device assessments and the date these were to be submitted to the provider; training for managers on a new electronic system for booking agency staff; and information on how managers could recommend staff for an 'Alliance Hero' award. This was a scheme where staff could be nominated to receive recognition and a gift voucher from the company for having embodied the company values in their work.

Management of risk, 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. However, it was not clear which provider was responsible for risks shared with another location.

The service had a business continuity policy, which included specific actions to take in the event of an unplanned disruption in service. The plan included specific instances, such as, loss of electricity, and identified actions staff should take to mitigate risks.

As a subsidiary of Alliance Medical UK Limited (AML). The service reported to the AML integrated governance and risk board (IGRB). The board was established to provide assurance that appropriate governance and risk management mechanisms were implemented and effective throughout the AML group. AML had a range of quarterly sub-committees these were based around the main risks to the company. Minutes from these meeting were available to all staff in the AML group via the company intranet.

The medical physics expert audited compliance with regulations relating to the use of ionising radiation on 14 April 2021. The audit reported that a radiation protection committee was in place and the centre was compliant with Ionising Radiation (Medical Exposures) Regulations (IRMER), regulations.

We viewed the centre's risk register. The register contained 44 identified risks. Risks were identified by the type of risk, for example, financial, operational or patient safety risks. The risk register used a traffic light red, amber, green (RAG) system. The risk register also identified the likelihood and potential impact of risks. The service had 14 amber rated risks; all other risks were green rated. However, the risk register recorded work was in progress on all amber rated risks.

The European Scanning Centre had a quality assurance review (QAR) dated January 2022. This reported that the centres in Harley Street and the provider's other location had several "combined risks" on the risk register. It was unclear whether the European Scanning Centre (Harley Street) Limited or AML had overall responsibility for managing the combined risks. This was due to the other London centre having AML as the registered provider, whilst European Scanning Centre (Harley Street) Limited were the registered provider for the Harley Street centre.

Information Management

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.

Data protection was part of staff mandatory training. We reviewed the mandatory training spreadsheet dated 16 March 2022; this recorded that 91% of the centre's staff had up to date training in data protection.

AML completed annual self-assessment of compliance with the Department of Health information governance policy and standards via the 'Data Security and Protection Toolkit'. The AML self-assessment in June 2021 was "standards met". AML were also reaccredited with Cyber Essentials in October 2020. This is a standard to protect information from cyber-attacks.

AML were compliant with the information security standard and certification for the AML group was valid until October 2023.

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' views and experiences were regularly gathered and acted on to shape and improve the services and culture. Staff were able to talk about changes that had been implemented following feedback from patients.

The provider conducted an annual staff survey. Results from the 2021 staff survey recorded that over 95% of staff would recommend the service to their friends or family. Over 75% of staff responded they would strongly recommend the centre as a place to work and 91% responded that they recognised clinical quality being delivered. The survey found 86% of staff felt they had developed their skills and knowledge whilst working for the provider.

AML had weekly operational managers meetings. These were weekly meeting where the provider cascaded information to managers. A presentation from the meeting held on 1 March 2022 recorded that the meeting was led by the chief operating officer, the director of quality and risk and the director of human resources. For example, updates to the COVID-19 procedures were cascaded to staff during the meeting. The meetings were conducted by video conference and were recorded to enable staff and managers, that could not attend the meeting, to watch a video of the meeting and share the learning.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The service had been acquired by AML in 2019. The new owners of European Scanning Centre were in the process of introducing robust systems and processes to enable the provider to monitor improvements, as well as the quality and safety of services for patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (2) (g)** —(1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include—(g) the proper and safe management of medicines; • The service's medicines management policy did not contain details of adverse effects and double checking of glycerine trinitrate (GTN) prior to administration. The policy did not clearly set out procedures for the administration of patient specific drugs (PSD). • The service did not ensure there was a system of regular medicines administration audits which included checks on the correct completion of PSD administration forms, including identifiable patient information. • The service did not ensure PSD records drug administration lists were completed accurately and risks of ambiguity about patients prescribed medicines on PSD forms were addressed.