Oryon Imaging and Healthcare Ltd

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?	Not sufficient evidence to rate
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Oryon Imaging and Healthcare Ltd is operated by Oryon Imaging and Healthcare Ltd. Facilities include one MRI scanner, one x-ray machine, one dexa scanner, one ultrasound consulting rooms and one spare consulting room.

The service only provided diagnostic imaging and we inspected the service using our diagnostic imaging core service framework. We carried out an unannounced inspection on 17 December 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.

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

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

We found good practice in relation to diagnostic imaging care:

- 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.
- 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.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment competently. Staff managed clinical waste well.
- Staff identified and quickly acted upon patients at risk of deterioration.
- 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.
- The service provided care and treatment based on evidence-based practice.
- Staff ensured that patients remained comfortable during their examination.
- 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.
- Healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care and meets the demands of patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients to minimise their distress.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- The service planned and provided care in a way that met the needs of patients.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- People could access the service when they needed it and received the right care promptly.
- 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.
- Managers had the integrity, skills and abilities to run the service. They were visible and approachable in the service for patients and staff.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action.

Summary of findings

- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.
- 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.

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

- Staff understood how to recognise abuse and had appropriate training However, at the time of the inspection clinical staff were not confident in explaining their safeguarding process.
- The service did not keep complete fit and proper persons records for the company director.
- There was variable knowledge of the values, vision and strategy amongst staff at the service.
- Patients and staff did not have access to a translation service.

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

Nigel Acheson

Deputy Chief Inspector of Hospitals

Summary of findings

Contents

Good

Oryon Imaging and Healthcare Ltd

Services we looked at
Diagnostic imaging

Summary of this inspection

Background to Oryon Imaging and Healthcare Ltd

Oryon Imaging and Healthcare Ltd is operated by Oryon Imaging and Healthcare Ltd. The service opened in 2012. It is a diagnostic centre in London. The hospital primarily serves the communities of the greater London area and some international patients. It also accepts patient referrals from outside this area.

The hospital has had a registered manager in post since 2012 At the time of the inspection, a new manager had recently been appointed and was registered with the CQC in 2017.

Our inspection team

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

Information about Oryon Imaging and Healthcare Ltd

The service is one department with consulting rooms, treatment rooms and diagnostic imaging machines and is registered to provide the following regulated activities:

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

During the inspection, we visited all areas which included MRI, Dexa, X-ray and ultrasound. We spoke with 6 staff including radiographers, technicians, reception staff and managers. We spoke with 4 patients. During our inspection, we reviewed 5 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The service has not been inspected before, this was the services first inspection since registration with CQC, which found that the service was meeting all standards of quality and safety it was inspected against.

Track record on safety (October 2018 to October 2019)

- No Never events
- No serious injuries

No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),

No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)

No incidences of hospital acquired Clostridium difficile (c.diff)

No incidences of hospital acquired E-Coli

27 complaints (formal and informal)

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Grounds Maintenance
- Cleaning and housekeeping
- Radiation protection service
- Laundry
- 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?

Good

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 recognise abuse and had appropriate training.
- 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.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment competently. Staff managed clinical waste well.
- Staff identified and quickly acted upon patients at risk of deterioration.
- 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.
- 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.
- The service used systems and processes to safely administer, record and store medicines.
- The service managed patient safety incidents well.

However:

- Clinical staff were not confident in explaining their safeguarding process.

Are services effective?

Not sufficient evidence to rate

We do not rate effective for this type of service. We found the following areas of good practice:

- The service provided care and treatment based on evidence-based practice.
- Staff gave patients enough food and drink to meet their needs.
- Staff ensured that patients remained comfortable during their examination. The service did not assess pain or administer pain relief.
- Staff monitored the effectiveness of care and treatment as appropriate for the size of the service.

Summary of this inspection

- 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.
- Healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care and meets the demands of patients.
- Staff gave patients advice in relation to their procedure.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Are services caring?

Good

We rated it as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients to minimise their distress.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Are services responsive?

Good

We rated it as **Good** because:

- The service planned and provided care in a way that met the needs of patients.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- People could access the service when they needed it and received the right care promptly.
- 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.

However:

Patients and staff did not have access to a translation service

Are services well-led?

Requires improvement

We rated it as **Requires improvement** because of a breach of regulation and other findings:

Summary of this inspection

- The service did not keep complete fit and proper persons records for the company director.
- There was variable knowledge of the values, vision and strategy amongst staff at the service.

However, we found the following areas of good practice:

- Managers had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.
- The service had sound governance system appropriate for the service.
- 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 could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.
- Leaders and staff actively and openly engaged with patients and staff to plan and manage services
- Staff told us they were committed to continually learning and improving the service.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Not rated	Good	Good	Requires improvement	Good
Overall	Good	Not rated	Good	Good	Requires improvement	Good

Good

Diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are diagnostic imaging services safe?

Good

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Mandatory training was provided regularly to all staff through a mix of both classroom and online sessions. Staff told us they were given time within their working day to complete this. Mandatory training was monitored by the service governance manager.
- Staff training files included a contemporaneous training record. This included details of training undertaken including; fire safety and evacuation, health and safety, equality and diversity, infection prevention and control, manual handling, safeguarding adults and children, conflict resolution, basic life support (BLS), intermediate life support (adults and paediatric), information governance and consent.
- We were provided with data that showed staff members had completed their training modules, the service was having various issues with the training matrix they had purchased and instead were having to use a spreadsheet. The data showed that from the six permanent clinical staff members had 100% compliance in all training modules except paediatric intermediate life support. The data showed that from the six permanent non-clinical staff members all were compliant with training.

Safeguarding

- **Staff understood how to recognise abuse and had appropriate training. However, clinical staff were not confident in explaining their safeguarding process.**
- After the inspection we were provided with evidence to show that all clinical staff had completed safeguarding training level one and two for both children and adults. The new imaging lead that was employed after the inspection had completed safeguarding level three for children and the centre manager had completed level three training for both adults and children.
- Staff understood the importance of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse. However, staff we spoke with were not confident in describing what they would do in a safeguarding situation.
- The service had a safeguarding policy, although it was not version controlled and did not contain any date to when it was last reviewed. We found that the safeguarding policy did not contain any details of where to escalate safeguarding concerns to outside of the organisation. Clinical and non-clinical staff we spoke with told us that they would escalate any safeguarding concerns to the imaging lead or governance manager, but we found that overall staff were unsure when describing the escalation process. The service has never had any safeguarding concerns or incidents in their history.
- We found that radiographers conducted identification checks complaint with IR(ME)R and the society of radiographers pause and check system.
- The service had a chaperone policy and signs advertising this service were available to patients.

Cleanliness, infection control and hygiene

Good

Diagnostic imaging

- **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.**

- The service had infection prevention and control (IPC) policies and procedures which provided staff with guidance on appropriate IPC practice, such as isolation and communicable diseases.
- We observed all areas of the service to be visibly clean. The imaging staff cleaned the imaging rooms at the end of each day. This was recorded on a daily check sheet which was reviewed by the manager each week. The external cleaning company cleaned each non-clinical area every day and a deep clean was conducted every three months.
- An IPC audit was done every other month and included environment, kitchen, linen, hand hygiene, personal protective equipment, waste disposal, sharps, management of patient equipment and treatment room. We saw the results of the environmental audit for the two months prior to our inspection, which showed overall compliance scores of 99% for both September and November 2019. Appropriate actions had been taken where necessary, such as ensuring sharps bins were wall mounted and sweeping and mopping floors.
- Staff followed manufacturers' instructions and the service's IPC guidelines for routine disinfection. This included the cleaning of medical devices between each patient and at the end of each day. On the day of inspection, we saw staff cleaning equipment and machines following each use. We reviewed all machines in use and saw the machines had been disinfected where appropriate.
- We saw there was access in all areas to hand washing facilities, hand sanitiser and supplies of personal protective equipment (PPE), which included sterile gloves, gowns and aprons. All staff were bare below the elbows and used PPE where necessary.
- 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. Hand hygiene audit results for September and November 2019 showed a 96% compliance rate.

Environment and equipment

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

- The layout of the centre was compatible with health building notification (HBN06) guidance. There was a basement level reception area accessible by lift, with a reception desk that was staffed during opening hours. The waiting area provided drinking water, light refreshments and toilet facilities for patients and relatives. We found toilet facilities for patients were clean and well maintained.
- Staff had sufficient space in each room for scans and x-rays to be carried out safely. There were appropriate diagnostic imaging observation areas. These ensured patients were visible to staff during examinations.
- During MRI scanning all patients had access to an emergency call alarm, ear plugs and ear defenders. There was always a microphone that allowed contact between the radiographer and the patient.
- The imaging equipment was owned by the provider. All equipment conformed to relevant safety standards and was regularly serviced. For example, equipment met the requirements of the Ionising Radiation (Medical Exposure) Regulations 2017 (IRR17) regulation 15. This sets out the general requirements in respect of all equipment, regardless of when it was installed and brought into clinical service. The service also met regulation 15(3) regarding testing of equipment. Equipment was tested before clinical use by the centre's radiographers. We saw evidence of monthly and annual quality assurance checks on imaging equipment as appropriate.
- There were systems in place to ensure repairs to machines or equipment were completed and that repairs were timely. Any issues would be logged in a fault book by the service radiographers, who liaised directly with the machine manufacturers. This ensured patients would not experience prolonged delays to their care and treatment due to equipment being broken and out of use. The service did not have a formalised equipment replacement programme or servicing programme, instead service and upgrades of equipment were carried out by manufacturer recommendations.

We found that staff were not aware of the exact age of the MRI scanner and we were told it had been upgraded in the recent years, the service did not maintain a comprehensive equipment inventory.

- All non-medical electrical equipment was electrical safety tested.
- 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'.
- Resuscitation and difficult airway equipment was available, with evidence of daily and weekly checks to demonstrate that equipment was safe and fit for use. The resuscitation equipment was 'MR safe' and was marked as such. There were procedures in place for removal of a patient that became unwell whilst scanning was taking place.
- Access to the imaging rooms was controlled via locked doors. There was signage on all doors explaining the magnet strength and safety rules, or radiation warnings and lights, as appropriate.
- Room temperatures were recorded as part of the daily MRI checks. 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 imaging lead and the service company.
- Clinical and domestic 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 sort different types of waste. Staff used sharps appropriately; the containers were dated and signed when full to ensure timely disposal, not overfilled and temporarily closed when not in use.
- The service monitored radiation exposure to staff through monitoring badges which were sent for analysis to an external company through out the year at regular intervals. The radiation protection supervisor reported there were no incidents of staff going beyond expected exposure levels in their history.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for most patients and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration**.
- The service ensured that the right person got the right scan at the right time, by following the recommendation from the Society and College of Radiographers to use a 'pause and check' system. This is a system of checks that need to be made when any diagnostic examination is undertaken. Radiographers used a three-point patient identification checking system. In the event of a patient informing staff that the area to be examined was different from that on the referral form, the centre's staff contacted the referrer to clarify the area to be examined and request a new referral if necessary.
- All clinical staff were intermediate life support trained for both adults and children. There were emergency alarms available across the imaging department, which we saw were operational. In the case of an emergency situation such as a deteriorating patient, the team would stabilise the patient and use the '999' system to transfer the patient to a NHS emergency department.
- The radiation protection advisor (RPA) and medical physics expert (MPE) were provided by an external company and this arrangement was part of a service level agreement. Staff at the service were not sure of the name and identity of the RPA or MPE but did show us the agreement which contained contact details and office hours. Staff told us that the RPA and MPE did not attend any governance meetings at the service but did provide an annual report based on data shared with them. The service did have an appointed radiation protection supervisor.
- The service ensured that the 'requesting' of any type of imaging was only made by staff in accordance with IR(ME)R. All referrals were checked by the radiographers prior to imaging, and all forms included patient identification, contact details, clinical history and the type of examination requested, as well as details of the referring clinician.
- Staff assessed patient risk and developed risk management plans in accordance with national guidance. For example, the unit used a MRI patient safety questionnaire. 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 until it was established with the referrer that these were MRI safe.
- Staff assessed patient risk before administering contrast agents, patients were asked to complete a questionnaire where relevant medical history, allergies and if the patient was breast feeding was confirmed. All

appropriate staff were trained in a professional cannulation course and the service had access to medications and equipment needed to deal with anaphylaxis.

- Radiographers understood their responsibility to report any significant unintended or accidental exposure to ionising radiation. The manager knew that if exposure levels were too high, there was a requirement to report this to the CQC and Health and Safety Executive (HSE).
- The centre had control measures including warning lights and signage to identify areas where radiological exposure was taking place. This was in accordance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 2017) and Ionising Radiation (Medical Exposure) Regulations 2000/2018. This ensured that staff and visitors did not accidentally enter a controlled zone such as X-ray when a procedure was in progress.
- Signs were located throughout the unit in both words and pictures highlighting the contraindications to MRI including patients with heart pacemakers, patients who had a metallic foreign body in their eye, or who had an aneurysm clip in their brain. These patients could not have an MRI scan as the magnetic field may displace the metal. There was also signage informing patients and visitors of the magnet size and informing them that the magnet was constantly on.
- Women had to complete a written self-declaration regarding their pregnancy status. This was also checked verbally by staff before a scan took place.
- There were processes to escalate unexpected or significant findings, both at the examination and upon reporting, which staff described. The reporting radiologist was contacted by a member of staff to advise them of the urgent report to ensure it received prompt attention. All images would be sent to the referrer urgently via the image exchange portal. If at time of examination, the radiographers thought the patient needed urgent medical attention, the patient was advised where appropriate to attend the nearest NHS emergency department or make an urgent appointment with their GP.
- We found that the local rules were in compliance with ionising radiation regulations but were out of date and staff we spoke with were not sure when they were next due to be reviewed. The employer's procedures were in compliance with IR(ME)R, but we found that not all staff had signed to confirm they had read these procedures.

Allied Health Professional 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, and gave agency and locum staff a full induction**
- The service did not use an acuity tool to calculate staffing levels and instead used a simple rota system which was appropriate for the size of the service. The service had two MRI radiographers working to ensure that to minimise delays, ensure the staff were not stressed and patients were safe. In the other modalities (X-Ray and Dexa), the service was offered Monday to Friday 9:00am to 5.00pm and one X-Ray radiographer and one Dexa technician were deemed sufficient. There was a clinical manager who was on duty Monday to Friday.
- During times of sickness and annual leave, if the existing team was not enough to cover, the service relied on a pool of bank staff to ensure that staffing levels were maintained. The bank staff were interviewed, received induction and training, as well as regular updates to ensure that they were confident and skilled to carry out their duties.
- The staffing levels were reviewed regularly and were deemed adequate. This was established mainly by reviewing patient comments, any delays to the service, any incidents, as well as team members comments, satisfaction levels and stress levels.
- The service employed one centre manager, one clinical manager (imaging lead), four reception staff, five senior MRI radiographers, one general x-ray radiographer, one dexa technician, one part-time healthcare assistant, one human resource finance manager, one human resource office assistant and 22 administrative staff (located off-site).
- At the time of the inspection the service had two vacancies for the clinical manager (imaging lead) and administrative staff.
- In the three months prior to the inspection 47 shifts were worked by bank MRI radiographers, nine shifts were worked by bank x-ray radiographers and seven shifts were worked by bank HCA staff. The service used agency staff for four x-ray shifts.

- The average sickness rates for the three months prior to the inspection for all staffing groups ranged from 2%-7%, the service did not have sickness rate targets due to their size but this was adequately managed.

Medical staffing

- **The service had access to 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.**
- The service employed three consultant radiologists under practising privileges who did reporting for scans, x-rays and held ultrasound clinics. The service has access to a further 10 external radiologists that didn't attend the service but provided remote reporting.
- Radiographer staff reported to us that radiologist were easy to get in contact with and could be contacted for emergency reporting or queries related to referrals. One radiologist was employed as the clinical lead for the service and would attend governance meetings and provide guidance and oversight to clinical practice at the service.
- We checked the staffing records for the three consultants attending the service and found the records to have up to date DBS checks, appraisals, evidence of mandatory training undertaken at their NHS hospital, references and indemnity insurance. The records for the other 10 external consultants showed that they all currently worked for NHS trusts.

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 care records were electronic and were accessible to staff. Patients completed a safety screening questions and staff recorded the patients' consent to care and treatment. This was later scanned onto the electronic system and kept with the patients' electronic records, with the paper copy being securely disposed of.
- 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.
- The service was able to receive referrals electronically and was actively promoting this with its external referrers, however the majority of referrals received were still paper based. External referrers that had an ongoing arrangement with the service had access to the Oryon imaging referral form, otherwise patients could arrange for a letter which was stamped and signed by the referrer. Referrals were also able to be received by fax and this was done in accordance to best practice to ensure confidentiality.
- Any images or scanned documentation relating to the patients' scans were transferred to a bespoke electronic portal that was accessible by the service, external referrer and the patient. This gave the referring consultant access to both the images taken and the radiologist's report. Patients had access to their images but could not access the radiologist report..

Medicines

- **The service used systems and processes to safely administer, record and store medicines.**
- The service used patient group directions (PGDs). PGDs allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. Medicines covered in the PGDs included contrast agents and sodium chloride. Staff were assessed to ensure they were competent to administer these medicines, with appropriate administration records kept for each patient. These medicines were stored appropriately and in date.
- We checked the medicines fridge (where only contrast agent was stored) and we saw records which showed staff had checked the fridge temperature daily. All temperatures recorded were within the expected range.
- Patients were asked about their allergies, as part of the safety questionnaire in line with best practice guidance, prior to medicines or contrast being administered.
- The service did not use any controlled drugs. The service maintained a log of all medicines administered by clinicians.
- We saw evidence to show medicines were disposed of appropriately.

Incidents

Good

Diagnostic imaging

- **The service managed patient safety incidents well. 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.**
- A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. There were no never events reported in the 12 months prior to this inspection.
- In accordance with the Serious Incident Framework, the service reported no serious incidents (SIs) in the 12 months prior to this inspection. There had been no Ionising Radiation (Medical Exposure) Regulations IR(ME)R / Ionising Radiation Regulations (IRR) reportable incidents in this period.
- The service had an incident reporting policy and procedure to guide staff in reporting incidents. Staff understood their responsibilities to raise concerns, to record safety incidents, and investigate and record near misses. Staff reported incidents using an electronic reporting system, with the governance manager ensuring that incidents were investigated and discussed during governance and staff meetings.
- The duty of candour is a regulatory duty that related 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. Staff we spoke with were aware of the duty of candour. There had been no incidents when statutory duty of candour had to be used in the 12 months prior to this inspection.

Are diagnostic imaging services effective?

Not sufficient evidence to rate

Evidence-based care and treatment

- **The service provided care and treatment based on evidence-based practice.**
- The service broadly followed guidance and policies developed in line with the Health and Care Professions Council, Public Health England (PHE), Society of Radiographers and the Medicines and Healthcare products Regulatory Agency, but staff present at the time of the inspection were unsure if they were following all applicable National Institute for Health and Care Excellence (NICE) guidelines for diagnostic procedures. However, after the inspection we were provided evidence from the imaging lead to show that the service had a formalised structure to seeking and implementing guidance as it was released.
- We found that the service followed NICE guidelines in relation to minimising the risk of contrast induced acute kidney failure by ensuring blood test results were available within the desired range before proceeding with the scan.
- National Dose Reference Levels (NDRL) were based upon PHE 'HPA-CRCE-034: Doses to patients from radiographic and fluoroscopic X-ray imaging procedures in the UK (2010 review)'. We found that the doses given were audited annually. Doses for children had been checked and approved by the medical physics expert.
- The service based its policies and procedures on the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 2017) and Ionising Radiation (Medical Exposure) Regulations 2000/2018. The local rules were up to date and reflected both equipment usage and the services localised practice. The local rules were on display.
- The service had local rules based upon 'Safety in magnetic resonance imaging,' (2013), guidelines. We found the local rules provided clear guidance on areas relating to MRI hazards and safety and the responsibilities of MRI staff to ensure work was carried out in accordance with the local rules.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs.**
- Patients were provided with instructions about fasting before their scans, if appropriate. Patients with diabetes would be flagged at the referral stage. Staff told us they would monitor these patients to ensure they maintained a normal blood glucose level if they needed to be nil by mouth prior to their scan.

- Patients had access to drinking water and a tea/coffee making machine whilst awaiting their examination. There were also light snacks available in the main waiting area.

Pain relief

- **Staff ensured that patients remained comfortable during their examination. The service did not assess pain or administer pain relief.**
- Pain assessments were not undertaken by the imaging service directly. The service did not provide pain relief to patients. Patients managed their own pain and 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

- **Staff monitored the effectiveness of care and treatment as appropriate for the size of the service.**
- The service maintained an annual audit schedule which contained local audits such as the health and safety audit, report and image quality audit, infection control audit and monthly QA audit. The schedule also contained evidence to show that the service conducted medical physics and radiation protection audits for the different modalities used.
- The service had 5% of their MRI reports and 2% of x-ray reports externally audited monthly. They logged any report queries from referrers on their system and reviewed the data on a regular basis to analyse any trends or improvement needed. Results of the audits for the 12 months prior to this inspection showed that the reports were largely in line with professional expectations.
- Staff that we spoke with told us that audit results, effectiveness and outcomes were a regular discussion subject in staff meetings. Managerial staff told us the service checks effectiveness through user feedback, reviews, referrers feedback, spot checks, observations, audits.

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. There was an induction and probation period for clinical staff during which clinical competencies were assessed.**
- There were arrangements in place for supporting new staff at the service, including an induction and probation period during which clinical competencies were assessed. Staff were required to complete a competency checklist within the first three months of employment and did not work until the required competencies had been met. This ensured all staff were competent to perform their required role. We viewed induction records for clinical staff, which included competency checklists. Staff that we spoke to were satisfied with the induction process and how it prepared them for their role.
- Staff could access a variety of short courses, educational seminars and teaching sessions aimed at healthcare professionals and taught by senior clinicians through the service's sister company which provided such training and educational sessions to doctors, nurses and allied health staff across the country. Staff told us that sessions they have attended were very useful regarding continuous professional development and included topics to do with radiology, medicines, latest medical advancements, general medicine etc.
- All radiographers undertaking MRIs had been trained in cannulation. Radiation protection and IR(ME)R update training was given by the radiation protection supervisor at location level.
- Staff we spoke with told us that they were able to attend relevant external courses to enhance professional development and this was supported by the organisation and local managers. Radiographer staff told us that learning, and development was a standing agenda item during appraisals and team meetings.
- Radiographers' performance was monitored through peer review, with radiologists feeding back any performance issues with scanning to enhance learning or highlight areas of improvement in individual radiographers' performance.
- We saw evidence of formal staff appraisals which occurred every six months. We saw evidence of the planned appraisal cycle. Data provided to us showed that all staff had an appraisal in the 12 months prior to this inspection.

Multidisciplinary working

Good

Diagnostic imaging

- **Healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**
- Staff told us there was good teamwork between various professionals within the service. On the day of inspection, we observed good working relationships between all grades of staff and professional disciplines.
- Due to the size of the service there were no formalised multidisciplinary team meetings, but we saw evidence that radiographers could access radiologist staff at any time. Radiographer staff told us that they had a good working relationship with radiologist staff and that they were helpful and understanding. Staff also had good relationships with their referrers which included GPs, consultants from neighbouring private clinics, nurses and other allied health professionals

Seven-day services

- **Key services were available seven days a week to support timely patient care and meets the demands of patients.**
- The service was operational from 8am to 10pm, Monday to Friday. In addition, the service opened on Saturday and Sunday 8am until 8pm in line with patient demand. A walk-in x-ray service was available Monday to Friday 9am to 5.30pm.

Health promotion

- **Staff gave patients advice in relation to their procedure.**
- There was patient information on diagnostic imaging procedures available on the service's website and in the waiting area and reception area.
- Patients were provided with information on what actions they needed to take prior to their scan. For example, whether they should eat or drink anything, including amounts of fluid intake and the timescales for eating or drinking, or what to wear. Advice was also provided for patients suffering from claustrophobia and these patients were also offered dummy runs of scans so they could get used to the environment.
- We saw leaflets and posters that advertised services for general health conditions such as weight loss and smoking cessation.

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.**
- We saw evidence that systems were in place to obtain verbal consent from patients before carrying out procedures and treatments. We observed staff gaining consent from patients before procedures took place. Staff we spoke with understood the need for consent and gave patients the option of withdrawing consent and stopping their scan at any time. The service did not use consent forms but did note verbal consent in patient records and collected signed safety questionnaires prior to scanning.
- Where a patient lacked the mental capacity to give consent, guidance was available to staff through the corporate consent policy. Staff we spoke with told us that patients lacking understanding or capacity to consent were not scanned or imaged and a discussion was held with the referrer. The service did not undertake scans or images until the referrer could confirm the patient understood the reason for the imaging.
- Mental capacity act training was provided as part of the mandatory training package for staff, in addition the governance manager held bespoke training sessions for staff in April 2019.

Are diagnostic imaging services caring?

Good

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- We observed interactions between staff and patients prior to, during and following procedures. Staff introduced themselves prior to the start of a patient's treatment, explained their role and what would happen next. Staff had a caring, compassionate and sensitive manner. All patients we spoke with were consistently positive about the care they received, telling us staff were "friendly" and "helpful".
- Staff ensured that patients' privacy and dignity was maintained during their time in the service and during

any scanning. Patients that chose to wear a gown during their scan stayed in the respective changing rooms, which were located close to the appropriate scanning rooms, whilst waiting for their scan.

- There was a chaperone policy in date and patients were informed that they could have a chaperone present for their scan. A chaperone is a person who serves as a witness for both patient and clinical staff as a safeguard for both parties during an examination or procedure. All staff we spoke with understood their responsibilities in relation to chaperoning and offering this service to patients.
- The service conducted a patient feedback survey results for the period of October 2018 to October 2019 showed that there were 1140 responses. Patients were asked to rate the service between one and five stars, the results showed the average rating to be 4.7 stars. The results showed 96% of patients said they would recommend the service to friends and family. We also saw evidence of a significant number of positive patient comments made at the end of the patient survey and sent to the service by email.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- Staff provided reassurance and support for nervous and anxious patients. They demonstrated a calm and reassuring attitude to alleviate any anxiety or nervousness patients experienced.
- Staff provided reassurance throughout the examination process, they updated patients on the progress of their examination. An alarm was available within the MRI scanner to enable patients to speak to the radiographer at any time. Patients were advised that if they wanted to stop their scan, staff would assist them. Staff told us patients that stopped their scan due to anxiety or claustrophobia could discuss choices for an alternative appointment, such as having a friend or family member to act as support or staff would discuss coping mechanisms to enable the patient to complete their scan, such as having their own music playing, wearing eye-masks or choosing a radio station to listen to. Patients that were identified as claustrophobic prior to their appointment were offered a trial run where they could take their time to see the scanner and mentally prepare.
- Staff allowed children to have extra time for their scans, they explained the procedure using simplified language and provided encouragement and reassurance throughout the procedure. We saw that staff gave children stickers as a reward for completing their procedure.

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.**
- On the day of inspection, we observed that staff communicated with patients and their relatives in a way they understood. All patients were welcomed into the reception area and reassured about their procedure. Patients were given enough time to ask questions and staff took time to explain the procedure and answer all questions in a calm, friendly and respectful manner.
- Patients and relatives were given clear information verbally and in written form before the appointment. Patients were provided with aftercare advice following a scan. Patients and their referrer could access information regarding the procedure, radiologist report and images through the service's electronic portal. Staff encouraged patients to contact them if they needed any further information anytime before or after the procedure.

Are diagnostic imaging services responsive?

Good

Service delivery to meet the needs of local people

- **The service planned and provided care in a way that met the needs of patients.**
- We found the environment of the service met the needs of its patients, there was enough seating available with access to light refreshments, entertainment and toilet facilities. We observed that there were toys and a quiet waiting area available for children or families. There was adequate signage for patients to find their way around. The service had access to a lift.

- All scanning undertaken was elective. Patients were offered scans at a time which suited them. The service offered extended opening times to suit the needs of their patients and offered weekend scans.
- The service offered transparent prices for their services and showcased live rates on their website, patients were free to choose appointments that suited their time or budget. Patients were not expected to pay before their procedure and could pay through insurance or self-funded methods.
- Patients were provided with information regarding their scan or procedure prior to attending and if they were walk-in patients they were provided with information of paper as well as verbal explanation. Patients that had booked in advance could access information through the electronic portal.

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. However, patients and staff did not have access to a translation service.**
- All staff had completed the equality and diversity course as part of their mandatory training. Staff understood the cultural, social and religious needs of the patient and demonstrated this in their work.
- Patients' personal preferences and needs were identified at the booking stage or at the time of the scan. Staff told us reasonable adjustments, such as extending appointment times and allowing relatives or carers into the imaging room could be made for patients with complex needs. Nervous, anxious or phobic patients could have a preliminary look around the department prior to their appointment to familiarise themselves with the environment and decrease anxiety.
- The service did not offer translation services and patients were required to bring their own interpreter. Staff told us that this was rarely an issue as most patients spoke English. The service did provide imaging for some Arabic patients who could access translation services from their respective embassies.
- Patients with reduced mobility could access the department as there was a lift, however due the building did not have step-free access.
- Chaperones were readily available.

Access and flow

- **People could access the service when they needed it and received the right care promptly**.
- Patients were able to book an appointment by themselves through the service's website, alternatively patients were signposted to the service by local clinicians and other healthcare services. Patients would not be scanned or imaged without a completed referral form or letter with the required information. Local clinicians were able to refer the patient directly using the electronic portal.
- Patients were able to choose and book appointment times suitable to their schedule, same day x-ray appointments were available.
- Every month the service sends 5% of their MRI scan reports and 2% of their x-ray reports to be externally audited for quality and timeliness. In the period of January 2019 to May 2019, there had been a total of 1,527 scans and x-rays reported. Of these, nine were MRI scans and 1,518 were x-rays.
- The service had a 24 hour report turn around time target and the results of the external audit showed that in the period of January 2019 to May 2019 about 93% to 98% of reports met the target, about 2% to 6% of reports were outside of the target and about 1% of reports were outside 48 hours. The average turnaround time varied between 16 to 18 hours.
- Images were available to clinicians immediately through the electronic portal and reports were uploaded as soon as they became available. Patients were only able to view images at the time of the inspection, but the service planned to allow patients to access the radiologist's report independent of their original referrer in the short term.
- Waiting times in the department were usually short, if there were any delays staff would inform patients when they were checking in. Staff told us that patients usually were in the department for 30 minutes from checking in to end of imaging.
- In the 12 months prior to the inspection no procedures had been cancelled due to reasons by the service. There were 131 delayed procedures in the 12 months prior to this inspection and they were caused by the MRI scanner breaking down in October 2018, December 2018 and May 2019.
- The service had approximately two appointments a week where patients did not attend, the service would contact the referrer to inform them.

Good

Diagnostic imaging

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.**
- Imaging department staff dealt with informal complaints in the first instance, with attempts made to resolve the complaint locally. In the case of a formal complaint, the service had a policy for handling complaints and concerns. The service aimed to resolve complaints within five working days, however we saw evidence to show that most complaints were resolved within 48 hours.
- The service did not subscribe to the Independent Sector Complaints Adjudication Service (ISCAS) for patients whose complaints could not be resolved by the service.
- Between October 2018 and October 2019, the service had received 27 complaints of which four were formal and the rest were informal. The main themes of the complaints were delays, pricing, communication, technical issues, diagnosis, level of service and service policies. There was no prevalent theme and there were no identifiable patterns to the complaints. In the same period the service received 108 formal compliments.
- We saw evidence in the form of meeting minutes to show that complaints were discussed in governance meetings and team meetings. The service had recently started to review informal complaints and comments received on review websites.
- Patients we spoke to said they would know how to make a complaint, and we observed the complaint process advertised to patients in the reception area.

Are diagnostic imaging services well-led?

Requires improvement

Leadership

- **Managers had the integrity, skills and abilities to run the service. They were visible and approachable in the service for patients and staff. However, the service did not keep complete fit and proper persons records for the company director.**
- The service was structured with the director as the head of the service and company, with the centre manager (also governance manager) reporting to the director and the clinical manger (imaging lead) reporting to the centre manager.
- The director was the nominated person and owner of the service and company, all staff spoke positively of the director and told us that the director was supportive and appreciative of their work. Staff told us they felt the director was approachable and would not have any problem in discussing any issues with them. The director visited the service twice a week and attended the weekly manager meeting.
- The centre manager had line manger responsibilities for the reception staff and the reception team leader. The centre manager was also responsible for corporate governance, operational oversight and registered manager.
- The clinical manager had line manger responsibilities for the senior MRI radiographers, x-ray radiographer and dexa technician. The clinical manager had oversight over clinical practice, technical issues and clinical governance.
- The service also had one of the three attending radiologist act as their clinical director, they would attend the weekly manager meetings and provide advice on clinical, regulatory and medical staff matters.
- Adjacent to the clinical service there was the business managers which included; human resource and finance manager, director of transformation, business development manager, technology and innovation manager and lastly the bookings manager.
- We looked at the fit and proper persons records for the company director, centre manager, clinical manager and clinical director. We found that all of them except for the company director's records had a valid DBS check, qualifications, professional registration where appropriate, references, mandatory training records, insurance where appropriate, proof of identity, contact details and proof of residence. The company director records only showed proof of identity and DBS check.

Vision and strategy

- **The service had a vision for what it wanted to achieve and a strategy to turn it into action. The**

vision and strategy were focused on sustainability of services. However, there was variable knowledge of the values, vision and strategy amongst staff at the service.

- Oryon imaging's vision was "to provide high quality, affordable, and convenient diagnostic imaging services in the heart of London's Harley Street district. The services be delivered by dedicated and approachable team in a friendly and professional environment that inspires confidence and reassures patients. They be approachable, caring and humane in all our interactions with patients and referrers. Their aim is to facilitate an efficient, affordable and clinically viable patient-focused service within a professional environment."
- Managerial staff we spoke with told us that their short term plan was to focus on further development of their electronic portal and continue to make processes more efficient. Longer term plans included the installation of an additional MRI scanner, focus on brand consolidation, improving efficiency, continuing quality improvement and exploring innovative practices.
- We saw evidence to show that strategy and goals were discussed, and progression monitored in governance and managerial team meetings.
- On the day of inspection, there was variable knowledge of the values and vision of the service amongst staff. Staff we spoke with told us that although strategic goals were discussed during team meetings, long term vision and values were not regular topics.

Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- Staff told us they had plenty of time to support patients. Staff told us they felt supported, respected and valued at both a local and corporate level. We observed good team working amongst staff of all levels, with collaborative ways of working embedded across the service.
- Equality and diversity were promoted within the service and were part of mandatory training. Staff told us there was a 'no blame' culture, with honesty and openness encouraged so learning from mistakes could take place.
- Staff were happy with access to continuing professional development and training within the organisation. We saw examples of staff within the service who had been encouraged to take on appropriate developmental tasks.
- All staff spoke positively of each other, the working culture and relationships with managers. Managerial staff we spoke with seemed to have a sound understanding of their colleagues and a positive rapport. Staff described the culture as "family feeling, open and co-operative".

Governance

- **Leaders operated an effective governance system which was appropriate for the service.**
- The service had clear and effective system of general governance and management. There was a clinical governance framework which aimed to assure the quality of services provided. Quality monitoring was the responsibility of the centre manager and was supported by the clinical manager. There were monthly governance meetings and weekly managerial meetings where incidents, regulatory matters, complaints, risks etc were discussed.
- The service had a formal agreement with an external company to provide radiation protection and governance services. The agreement was in place since 2014 and provided the service with radiation badge monitoring, regular equipment audits, and a named individual for the roles of radiation protection supervisor and medical physics expert. The external company provided an annual report which was reviewed and discussed in governance meetings. Staff we spoke with told us that there were no dedicated radiation protection committee meetings and the radiation protection supervisor or medical physics expert did not attend the clinical governance meetings, however information provided to us after the inspection showed that service had invited the medical physics expert to their clinical governance meetings in 2020.
- During the inspection staff were uncertain who the radiation protection advisor was, however the centre manager explained that this information was available on the service level agreement and was displayed on the wall near the reception area. After the inspection evidence was provided to us that showed a suitably

qualified individual was the radiation protection supervisor. Staff told us that they did not have regular meetings with this individual, but they were available anytime by phone or email.

- There were weekly staff meetings and radiographer staff we spoke with had a good understanding of incidents, risk and local performance. We saw departmental meeting minutes which demonstrated discussion of incidents and learning.

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.**
- Performance was monitored on a local level. Progress in delivering the service was monitored through key performance indicators (KPIs). The centre manager told us that KPI's were mainly based around scanning number, patient satisfaction, timeliness and revenue.
- The service outlined roles and responsibilities to managing and decreasing risk related to patient care and the work environment in the health and safety policy. The service had a valid major incident and business continuity policy.
- We saw the service's risk register, which was up to date and referenced ongoing risks. Risks were categorised into two subgroups; clinical and general. The risks were graded with level of risk and reviewed regularly, with appropriate actions taken to mitigate against them. An annual report on new and updated risks was discussed in the governance and staff meetings. Staff were able to tell us about their top risks which included; wheelchair user evacuation, MRI safety and administration of contrast agent.
- An annual audit program ensured performance was monitored and managed consistently. Staff participated in local audits, with the resulting information shared amongst staff to promote improvement. We saw appropriate action plans from audit results, and evidence that improvements had been made.
- The service had back-up generators in case of a power failure, we saw evidence to show they were tested for performance and reliability.

Managing information

- **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.**
- All staff at the centre had access to a shared drive where they could access policies and procedures, as well as paper copies located in an office. Staff told us there were sufficient numbers of computers in the centre. Staff had individual logins to access the computer systems as and when they needed to.
- All staff we spoke with demonstrated they could locate and access relevant information and records easily, enabling them to carry out their roles. Electronic patient records could be accessed easily but were kept secure to prevent unauthorised access to data.
- Radiology reports could be reviewed remotely by referrers to give timely advice and interpretation of results to determine appropriate patient care. Patients and referrers could view images as soon as they were available through the electronic portal.
- All staff had completed information governance training as part of their mandatory training and completed additional training on new EU wide legislation.
- Patients were provided with terms and conditions of the service as well as payment information. Basic information was available through the service website and more detailed information was provided at arrival.
- Advertising and promotional material was inline with the professional guidance and legislation on healthcare advertising as set out by the advertising standard authority.

Engagement

- **Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients**.
- Patient views about care and treatment were captured using a patient feedback survey. We saw evidence that informal comments were collated and fed back to staff in addition to this. As a result of patient suggestions, the service developed a new function on their electronic portal which allowed referrers to share the radiologist report with the patients if they were both users of the portal.

Good

Diagnostic imaging

- Due to the size of the service a staff engagement survey was not conducted, however staff we spoke with told us that they were able to raise concerns, suggestions and comments easily through other medium such as meetings, informally or appraisals.
- Staff attended monthly departmental meetings, designed to foster staff engagement, share information and drive forward improvement. We viewed minutes of staff meetings where staff were able to raise issues and discuss suggestions for improvement as needed.
- Staff we spoke with felt that they were appreciated for their work and were rewarded fairly. We were told that the company director had recently paid for and taken all the staff for a weekend holiday abroad.
- The service conducted employee of the quarter awards where colleagues could nominate each other and be recognised for their work. We were told that there was usually a small prize and certificate for the award.

Learning, continuous improvement and innovation

- **Staff told us they were committed to continually learning and improving the service.**
- We saw evidence of the service using an electronic portal which allowed instant access to images, reports, information, guidance and prices to referrers, patients and the staff working at the service. The portal could be used to share information and communicate securely and quickly.
- Staff felt the services approach to prices was innovation, initiatives included advertising live prices on their website which were updated regularly considering market competition, allowing patients to book appointments during peak and off-peak times to suit their budget and to allow patients to pay online.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that it appoints suitably qualified, competent, skilled and experienced individuals to any director roles, the provider must keep records to prove this.

Action the provider SHOULD take to improve

- The provider should endeavour to ensure that all staff are engaged with and aware of the service's vision and values.
- The provider should ensure that staff and patients have access to an appropriate translation service when required.

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 Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Fit and proper persons employed (1)(2)(a)** • The provider must ensure that it appoints suitably qualified, competent, skilled and experienced individuals to any director roles, the provider must keep records to prove this.

This section is primarily information for the provider

Enforcement actions

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.