

European Scanning Centre (Harley Street) 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

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Requires improvement



Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Summary of findings

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

Overall summary

European Scanning Centre (Harley Street) Ltd is operated by European Scanning Centre Ltd. European scanning centre (ESC) operates diagnostic imaging services across two other locations.

The service at Harley street consists of an Aquilion ONE 640 slice CT (computed tomography) scanner, a MRI Open upright and open MRI (magnetic resonance imaging) scanner, EOS dual source linear upright CT scanner (EOS imaging) and an Aplio 500 ultrasound scanner.

The service is split over three floors (basement, ground and first floor) within a building that has a shared entrance for residents residing on the third floor.

Patients are greeted by the receptionist and wait in a dedicated waiting room before being called through for their scan.

The service provides specialist diagnostic imaging services for adults, and children and young people.

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 15th January 2019, along with an unannounced visit to the service on 28th January 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.

The main service provided by this provider was diagnostic imaging.

Services we rate

We rated this service as **Requires improvement** overall.

- Although staff had training on how to report and recognise abuse, staff were not trained to an appropriate level in safeguarding.
- Labels on sharps bins were not correctly completed.
- Hazardous items were not always secured, and some areas were cluttered.
- Patient specific directions (PSDs) and patient group directions (PGDs) were not used for administration of contrast media or medication.
- The service had no robust systems for reporting incidents and it was not clear how learning from these, was shared or how practice was reviewed.
- There was no medicines management policy in place.
- The provider could not be assured staff understood their roles and responsibilities under the Mental Capacity Act 2005.
- Arrangements for identifying, recording and managing risks were not robust.
- There was no systematic programme of clinical audit to monitor quality or systems to identify where action should be taken.
- There was a lack of effective governance processes to assess, monitor and review risks.
- There were no meetings or formal measures of performance, except for financial performance.
- Monthly staff meetings were not minuted and action logs were not recorded.

However, we also found the following areas of good practice:

- MRI local safety rules were up to date and reflected best practice.
- There were systems to demonstrate staff were competent to do their jobs and develop their skills.
- There was good collaborative working to meet patients' needs.
- Patients were treated with dignity, respect and compassion.
- Patients were given the opportunity to ask staff questions, and patients felt comfortable doing so.

Summary of findings

- Staff provided patients with emotional support; staff were sympathetic to anxious or distressed patients.
- Same day appointments could be provided for patients.
- Patients could access services easily. There were no waiting lists.
- The service was planned and designed to meet the needs of the patients as it gave them access to timely scans.

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

Dr Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South)

Summary of findings

Our judgements about each of the main services

Service

Rating

Summary of each main service

Diagnostic imaging

Requires improvement



Diagnostic imaging was the only activity the service provided.

We rated this service as requires improvement because improvements were required for safe, and well led.

Summary of findings

Contents

Summary of this inspection

	Page
Background to European Scanning Centre (Harley Street) Ltd	7
Our inspection team	7
Information about European Scanning Centre (Harley Street) Ltd	7
The five questions we ask about services and what we found	8

Detailed findings from this inspection

Overview of ratings	10
Outstanding practice	28
Areas for improvement	28

Requires improvement



European Scanning Centre (Harley Street) Ltd

Services we looked at:

Diagnostic imaging

Summary of this inspection

Background to European Scanning Centre (Harley Street) Ltd

European Scanning Centre (Harley Street) Ltd is operated by European Scanning Centre Ltd. The service opened in December 2009. The service is in Harley Street, London.

The European Scanning Centre (Harley Street) Ltd provides a range of magnetic resonance imaging (MRI),

computed tomography (CT) and ultrasound examinations to primarily private fee-paying patients. The centre also provides services for patients referred from the NHS through clinical commissioning groups (CCG) or GPs.

The service has had a registered manager in post since 17 March 2011. The centre is registered with the CQC to undertake the regulated activity of diagnostic imaging.

Our inspection team

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

Information about European Scanning Centre (Harley Street) Ltd

The provider European Scanning Centre (ESC) has three locations. We inspected the Harley Street, London location.

This location had a CT scanner, an upright and open MRI, a dual source linear upright CT scanner and an ultrasound.

We inspected all four modalities. We spoke with nine staff including, health care assistants, reception staff, medical staff and senior managers. We spoke with three patients and one relative. During our inspection, we reviewed eight 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.

Activity (September 2017 to August 2018)

In the reporting period, ESC provided 750 attended appointments.

Staff in the unit consisted of a medical director, operations director, five radiographers and 14 non-clinical staff.

Track record on safety:

- No never events.
- No serious injuries.
- No incidences of healthcare acquired Methicillin-resistant staphylococcus aureus (MRSA).
- No incidences of healthcare acquired Methicillin-sensitive staphylococcus aureus (MSSA).
- No incidences of healthcare acquired Clostridium difficile (c. diff).
- No incidences of healthcare acquired Escherichia coli (E-Coli).
- No deaths.
- No formal complaints.

Services provided at the centre under service level agreement:

- Clinical and or non-clinical waste removal
- Interpreting services
- Maintenance of medical equipment
- Pathology and histology
- Mandatory training

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?

Are services safe?

We rated it as **Requires improvement** because:

- Not all staff had the appropriate level of safeguarding training for their role.
- There were no records of cleaning or audits of staff compliance with hand hygiene.
- Hazardous substances were not stored appropriately, and some areas were cluttered.
- The service did not follow best practice when prescribing and recording medicines.
- Staff recognised incidents but did not always report them appropriately. There was no formal procedure for sharing learning from incidents with staff.

However, we also found:

- Staff completed and updated risk assessment questionnaires for each patient.
- 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.
- Staff kept updated records of patients' care and treatment.

Requires improvement



Are services effective?

We do not currently rate effective for diagnostic imaging.

- The provider could not be assured that staff were fully aware of the requirements of the Mental Capacity Act 2005 and associated guidance.
- Staff worked collaboratively as part of a multi-professional team to meet patients' needs.
- The service could not be assured it provided care and treatment based on national guidance as there was a lack of systems to monitor evidence of its effectiveness.
- Managers did not monitor the effectiveness of care and treatment and use the findings to improve them; or compare local results with those of other services to learn from them.

Are services caring?

We rated it as **Good** because:

- Patients were treated with kindness, dignity and respect. This was reflected in feedback we received from patients.

Good



Summary of this inspection

- Patients received information in a way which they understood and felt involved in their care. Patients were always given the opportunity to ask staff questions, and patients felt comfortable doing so.
- Staff provided patients and those close to them with emotional support; staff were supportive of anxious, phobic or distressed patients.

Are services responsive?

We rated it as **Good** because:

- The service treated concerns and complaints seriously. Staff were encouraged by the provider to resolve complaints and concerns locally.
- The centre ensured a quick turnaround on the reporting of diagnostic scans.
- Patients were offered a range of appointment slots.
- Patients could access services when they needed them. Appointments were flexible and waiting times short. Appointments and procedures occurred on time.

Good



Are services well-led?

We rated it as **Requires improvement** because:

- Governance meetings, team meetings were not minuted so we could not be assured of the evidence of information of clinical risks and performance on the agenda.
- The service did not have a vision for what it wanted to achieve.
- The service did not use a systematic approach to continually improve the quality of its services.
- The service did not collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality.

However, we also found:

- Staff were positive about their local leaders and felt they were well supported.

Requires improvement



Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Requires improvement	N/A	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	N/A	Good	Good	Requires improvement	Requires improvement

Diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Requires improvement 

Mandatory training

- **The service provided mandatory training in key skills to staff.**
- The provider had a mandatory training policy which set out the training requirements for staff and frequency of the updates. Staff who had honorary contracts with an NHS provider could access the NHS providers portals and training facilities. Training was delivered via e-learning modules and face to face training.
- Mandatory training records showed that all staff (including administrative, management and radiography staff) had completed mandatory training in safeguarding children, safeguarding adults and medical emergencies. All radiography staff had completed infection control training and training in Ionising Radiation (Medical Exposure) Regulations (IRMER).
- Radiographers and health care assistants completed mandatory training courses annually or every two years.
- Staff told us they accessed their training records via an online training portal. On inspection we saw that some staff members' paediatric immediate life support training (PILS) and immediate life support training (ILS) had recently expired. We were assured that a refresher course had been booked in for the following month.
- On the unannounced inspection, we saw the service had sourced an alternative supplier to deliver the refresher training at a sooner date. Following the unannounced inspection, we were provided with staff members refresher certificates.

- Staff undertook a new site induction training. This training covered site responsibilities, first aid, accidents and incidents, fire procedures, emergency procedures, health and safety, biological hazards, policies, procedures and protocols, equipment used, store room and consumables, general housekeeping and patient pathways.
- There was evidence all clinical staff and at least one non-clinical staff member completed a training course in high-level probe disinfection procedures. This meant staff could ensure that equipment was kept to a high level of cleanliness.
- Staff who required additional training to develop in their role and maintain skills were given additional support for training.

Safeguarding

- **Not all staff had the appropriate level of training for their role**
- The lead for adults and children's safeguarding was a superintendent radiographer who was trained to level one. All staff, including the safeguarding lead, were safeguarding children level one trained. This did not meet intercollegiate guidance 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff', March 2014. Guidance states all non-clinical and clinical staff that have any contact with children, young people, parents or carers should be trained to level two safeguarding.
- We raised this with the provider and on a return unannounced inspection we saw online training for all members of staff to be qualified to level two had been arranged. In addition to this, all the radiographers and healthcare assistants would be qualified to Level 3.

Diagnostic imaging

- The service did not display information regarding safeguarding people from abuse in areas where people using the service would see it.
- We reviewed the safeguarding policy in place and found it did not cover topics dealing with female genital mutilation, modern slavery and human trafficking, patients requiring advocacy services and the rights of people subject to Mental Health Act 1983.
- European Scanning Centre provided services for children under the age of 16 years. We saw numbers for all local adult and child safeguarding team referrals were in the safeguarding policy.
- Staff were trained to recognise adults at risk and were supported by the provider's safeguarding adults' policy. Staff demonstrated that they understood their responsibilities and adhered to the company's safeguarding policies and procedures.
- The service offered all patients a chaperone. There was a policy for all intimate scans to be chaperoned and we saw evidence where a consent form was filled in and patients were provided chaperones for these scans.

Cleanliness, infection control and hygiene

- **Staff kept equipment and the premises clean.**
- The MRI scanner and rooms cleaning schedule set out the details of the cleaning required for the magnet room. This detailed the cleaning required before and after each patient, daily and weekly. The radiographer staff cleaned the MRI examination room daily to ensure magnet safety precautions for magnetic scanners was observed. We observed the scanner was cleaned after each patient by radiography staff.
- We observed the processes of decontamination of ultrasound probes to be thorough and robust and saw documented evidence of completion of decontamination.
- The service had an up-to-date infection prevention control policy that was regularly reviewed. It provided guidance on the use of personal protective equipment (PPE), such as gloves, handling of blood products, hand hygiene, handling of clinical waste, decontamination of equipment and environmental cleaning, including the use of spill kits.
- Sharps disposal bins (secure boxes for disposing of used needles) were located as appropriate across the service

- which ensured the safe disposal of sharps, for example needles. They were all clean and not overfilled. However, labels were not correctly completed to inform staff when the sharps disposal bin had been opened.
- There was sufficient hand sanitising gel in the clinical area and in waiting areas in the service and we observed staff using it. The five moments of hand hygiene was displayed near hand washing facilities.
 - A senior radiographer was the infection control lead who took responsibility for the internal auditing and ensured cleaning checklists were done. We were told that they were new to this position and had been booked onto additional training to support this role.
 - The service had not conducted an internal hand hygiene or cleanliness audit. The service did not have an annual infection control report or audit. We were therefore unable to comment on compliance.

Environment and equipment

- **The service had suitable premises and equipment, however hazardous substances were not always secured, and some areas were cluttered.**
- The layout of the centre was compatible with the Department of Health (DoH) health building notification (HBN06) guidance.
- The service had completed risk assessments for all new or modified use of radiation. We saw the risk assessments addressed occupational safety as well as risks to people who used the services and public.
- Rooms where ionising radiation exposures occurred were clearly signposted with warning lights; access was restricted when a scan was in progress.
- The clinical patient's areas were split over three floors (basement, ground and first floor). The upright MRI and CT were located in the basement accessed via a staircase and patient chair lift. The reception area was positioned in the entrance corridor and was located directly opposite the patient lounge. Adjacent to the patient lounge was a small kitchen that was used only by staff to ensure patients and their guests had refreshments and to make personal drinks throughout the day. Situated also on the ground floor were general office areas, a toilet, a blood test room, a consultation room and the Upright CT EOS scanner. The first floor had office space, the medical secretary office and the radiologist reporting room leading on to the ultrasound suite. The second and fourth floors were set up for office space and the third floor was a residential flat.

Diagnostic imaging

- The fringe fields around the MRI scanner were clearly displayed. Fringe field refers to the peripheral magnetic field outside of the magnet core. This reduces the risk of magnetic interference with nearby electronic devices, such as pacemakers. Although the strength of the magnetic fields decreases with distance from the core of the magnet, the effect of the “fringe” of the magnetic field can still be relevant and have influence on external devices.
- In accordance with Medicines and Healthcare products Regulatory Agency (MHRA) guidance, 5.4.6, scanning rooms were equipped with oxygen monitors to ensure that any helium gas leaking (quench) from the cryogenic Dewar (this is a specialised type of vacuum flask used for storing cryogenics such as liquid nitrogen or liquid helium), would not leak into the examination room, thus displacing the oxygen and compromising patient safety. Scanning rooms were also fitted with an emergency quench switch which was protected against accidental use and initiated a controlled quench and turned off the magnetic field in the event of an emergency. The magnet was also fitted with emergency “off” switches, which suspend scanning and switch off power to the magnet sub-system, but will not quench the magnet. Staff were fully aware of actions required in the event of an emergency quench situation.
- The MRI scanner was equipped with a phantom scanner, this is a specially designed quality assurance device that is scanned in the magnetic resonance imaging field of view to evaluate, analyse, and tune the performance of the scanner. We saw records confirming the radiographer performed a phantom scanner check daily prior to patients arriving for appointments.
- There were systems in place to ensure repairs to machines or equipment, when required, were timely. These ensured patients would not experience prolonged delays to their care and treatment due to equipment being broken and out of use. Servicing and maintenance of premises and equipment was carried out using a planned preventative maintenance programme.
- During our inspection we checked the service dates for equipment, including scanners. We found the equipment we checked was within the service date.
- MRI local safety rules were in place and reflected best practice. There was signage in place which detailed the magnet strength and safety rule.
- The magnet was fitted with emergency buttons which stopped scanning and switched off power to the magnet.
- MRI safe equipment such as a trolley for the safe transfer of patients and oxygen cylinders were available in the scanning room. MRI safe equipment is equipment that is safe to be used within the scanning room.
- The service maintained their diagnostic imaging equipment and ensured it was in good working condition and safe for patient use by having yearly portable appliance testing (PAT) and we saw evidence of this.
- All equipment had a servicing level agreement with the manufacturer. All equipment was well maintained and serviced regularly.
- We checked the resuscitation equipment which was located in the CT scanning room. The resuscitation equipment appeared visibly clean. Records indicated resuscitation equipment had been checked daily by staff. However, resuscitation medication was not locked away and therefore not tamper proof.
- The centre had one set of resuscitation equipment and medication for the whole service. If resuscitation equipment and medication was required in the MRI, CT EOS or ultrasound room it would need to be retrieved from the CT control room and taken to the relevant room or floor. If a CT scan was taking place at the time the scan would need to be paused. This could cause a potential to rescan if the patient moved and significant delay in response to an emergency situation.
- All MRI equipment was labelled in accordance with recommendations from the Medicines and Healthcare products Regulatory Agency (MHRA). For example, ‘MR Safe’, ‘MR Conditional’, ‘MR Unsafe’. All equipment in the assessment area was labelled MR unsafe.’ However, we saw a metal transfer chair that was unmarked. Staff told us they were aware that the frame should not be taken into the scanning area. However, it would be safe practice to mark all equipment that was not ‘MR safe’ to ensure all equipment was clearly identified. Staff told us this transfer chair would be used if the stairlift was unusable in the event of a power failure.
- Access to the MRI room was via a controlled door. There was signage on all doors explaining the magnet strength and safety rules.
- Staff had enough space to move around the scanner and for scans to be carried out safely. During scanning all patients were visible to staff and had access to an

Diagnostic imaging

emergency call/panic alarm. Patients could have music of their choice played whilst being scanned. Patients did not require ear plugs or defenders as the upright MRI system did not generate the levels of noise a conventional MRI scanner would generate. There was a microphone that allowed contact between the radiographer and the patient at all times.

- The service did not follow their own policy for Control of Substances Hazardous to Health (COSHH). For example, at the time of our inspection cleaning supplies were stored within space behind the IT generator room, there was no dedicated COSHH cupboard. The door to the IT generator room was unlocked and kept open by power cables going through. There was a potential risk of patients or their families accessing the room and coming into contact with cleaning supplies.
- On inspection, we found the room behind the generator store room to be cluttered. The room contained gowns, fruit juice cartons on the floor, washing machine, dryer, patient slippers, cleaning fluids, aerosols, contrast agent, boxes of sodium chloride infusions and an unlocked fridge which contained medication. There was a concern of fire risk as boxes were on top of each other within a cramped area. There was no mention of this area within fire safety report provided by the service. We raised our concerns with management on the day of inspection.
- Following our inspection, we saw evidence that the service obtained a locked cabinet to store all hazardous substances, including chemical products. On our unannounced inspection we saw the area had been cleared and boxes were disposed of. The door to the IT generator room was closed and the trailing cables had been cleared.
- Radiation badges located within the scanning areas were sent for reading and replaced every three months.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient.**
- Staff assessed patient risk and developed risk management plans in accordance with national guidance. For example, the unit used a magnetic resonance imaging patient safety questionnaire.
- Patients had the choice of wearing their own clothes or changing into a gown prior to the scan. This was due to magnetic fields used by MRI are very strong, and

metallic items on patients' clothes carry accident risks. Most of the patients we saw during the inspection changed into a gown. All patients told us they were given information, were risk assessed and had signed a form to accept they had understood the risks regarding their choice of clothing and MRI scanning.

- There was a standard operating procedure (SOP) for staff to assess people using services that were clinically unwell and needed to be admitted to hospital. The SOP gave instructions to staff on commencing resuscitation in the event of a medical emergency or cardiac arrest. This was to commence cardiopulmonary resuscitation (CPR) and dial 999.
- There were procedures for removal of a collapsed patient from the MRI scanner. However, there was no schedule of skills or drills training for the evacuation of a patient from the MRI scanner.
- The service ensured that the 'requesting' of an MRI was only made by staff in accordance with the MHRA guidelines. All referral forms included patient identification, contact details, clinical history and the type of examination requested, as well as details of the referring clinician or practitioner.
- Signs were located in the scanning area highlighting the contra-indications to MRI including patients with heart pacemakers, patients who had a metallic foreign body, and patients with an aneurysm clip in their brain. These patients could not have an MRI scan as there was a risk that the magnetic field may dislodge the metal.
- In accordance with NICE acute kidney injury (AKI) guidelines and the Royal College of Radiologists standards for intravascular contrast agent administration, all high-risk patients referred for MRI were blood tested for kidney function prior to scanning. This was to reduce the risk of contrast induced nephropathy (CIN). CIN is a renal impairment or acute kidney injury occurring within 48 hr of administration of intravascular radiographic contrast material that is not attributable to other causes.
- We saw evidence the potential risks of intravascular administration of contrast were weighed against the potential benefits. Systems were in place, including trained individuals that were able to recognise and treat severe contrast reactions, including anaphylaxis. At the service this role was fulfilled by a radiographer who had been appropriately trained.

Diagnostic imaging

- Scans that required contrast were only performed when a doctor or radiologist were on site, as they were paediatric resus and ILS trained.
 - The centre did not have a standard operating procedure (SOP) for urgent or unexpected clinical findings. Staff explained the processes to escalate unexpected or significant findings both at the time of the examination and upon reporting.
 - If radiographers thought a patient needed medical attention, the patient was advised to attend their local accident and emergency department or consult with their GP.
 - There were processes to ensure the correct person got the correct radiological scan at the right time. The service had a Society of Radiographers (SoR) poster within the unit. The posters acted as an aide memoire for staff reminding them to carry out checks on patients.
 - We saw staff using the SoR “paused and checked” system. Pause and check consisted of a system of three-point demographic checks to correctly identify the patient, as well as checking with the site or side of the patient’s body that was to have images taken and the existence of any previous imaging the patient had received
 - The service ensured that women (including patients and staff) who were or may be pregnant always informed a member of staff before they were exposed to any radiation in accordance with the Ionising Radiation Medical Exposure Regulations (IR(ME)R). IR(ME)R sets out the responsibilities of duty holders (the employer, referrer, IR(ME)R practitioner and operator) for radiation protection.
 - The service had named staff fulfilling the essential roles of radiation protection advisor, medical physics expert, radiation protection supervisor, senior radiologist and infection control lead. The service had appointed a radiation protection supervisor (RPS). Staff said the radiation protection advisor (RPA) and the medical physics expert (MPE) were readily accessible via the telephone for providing radiation advice.
 - There were local rules (IRR) and employer’s procedures in place (IR(ME)R) which protected staff and patients from ionising radiation.
 - A review was carried out at the location to assess compliance with the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER17) in April 2018.
 - Overall acceptable compliance was seen with IRR17 and IR(ME)R. The manager and radiology staff were aware of the local rules and procedures and these documents were reviewed on a regular basis. Most of the recommendations following this audit related to updating the current documentation to comply with the implementation of the new IRR17 and IR(ME)R regulations.
- ## Staffing
- **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.**
 - Required staffing levels were calculated using core service information including: operational hours, patient complexity and service specifications, physical layout and design of the facility/service, expected activities, training requirements, and administrative staffing requirements. This ensured enough staff to support patients’ needs.
 - Staff at the centre consisted of a medical director, operations director, five radiographers and fourteen non-clinical staff.
 - There was a business continuity plan to guide the service when responding to changing circumstances. For example, sickness, absenteeism and workforce changes. Agency staff were not used at the European Scanning Centre. Shifts were usually covered by the centre's own staff. This ensured staff continuity and familiarity with the unit.
 - During the reporting period, the average sickness rate was reported as 1% for permanent employees.
 - All staff felt that staffing was managed appropriately.
 - Radiologists worked under practising privileges. This meant the provider was assured that the consultants had the right qualifications, skills and experience which were necessary for the work performed by them. The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice, or within the provision of community services. The provider held details of the consultant GMC numbers, insurance and details of the NHS trusts they worked for.
 - A sessional radiologist was on site for four hours every day. All radiologists were required to submit annual

Diagnostic imaging

appraisals from their main employer. Any changes in their NHS lists, for example, ultrasounds they no longer do were duplicated and they were no longer permitted to perform them.

Records

- **Staff kept updated records of patients' care and treatment.**
- Patients completed a MRI safety consent checklist form consisting of the patients' answers to safety screening questions and recorded the patients' consent to care and treatment. This was filed in patient's individual patient records.
- Patients' personal data and information were mostly kept secure. However, on inspection we found the EOS scanning room was unattended and unlocked. The scanning room could be accessed by unauthorised persons. We found four sets of patient notes left unattended within the open and accessible EOS room. We raised this with management and they actioned the removal of notes and securement of the scanning room immediately.
- Only authorised staff had access to patients' personal information. Staff training on information governance and records management was part of ESC's mandatory training programme.
- Staff completing the scan, updated the electronic records and submitted the scan images for reporting by a radiologist.
- The quality of images was peer reviewed locally and quality assured on a corporate level. Any deficiencies in images were highlighted to the member of staff for their learning. However, this was very rare, and the services re-scanning rate was negligible.
- We reviewed eight patient records during this inspection and saw most records were accurate, complete, legible and up to date.
- The service provided electronic access to diagnostic results and could share information electronically with referrers.
- The radiology information system (RIS) and picture archiving and communication system (PACS) were secure and password protected, and each member of the clinical staff had their own personal password.
- For all specialist or doctor referred patients, their results are sent to the referrer. Two copies were sent, one for the patient and one for the referrer's records.

Self-referred patients received two copies and were encouraged to supply one of the copies to their GP. IEP facilities were available as well as remote access for referrers to obtain information and results on their patients.

- In line with the centre's policy, all patients' records were scanned and stored on disc, with the paper records then shredded.

Medicines

- **The service did not follow legislation when prescribing, administering and recording medicines.**
- Patient specific directions (PSDs) and patient group directions (PGDs) were not used for administration of contrast media or medication. PGDs allow some registered health professionals, such as radiographers, to administer specified medicines to a predetermined group of patients without them seeing a doctor. This was not in accordance with guidance on 'Prescribing' and guidance on the use of 'Contrast agents and other drugs,' from the Society and College of Radiographers (SOR).
- Staff told us they gave patients beta blockers (medication which decreases the activity of the heart by blocking the action of hormones such as adrenalin). These were prescribed by the referring doctor and was written on a drug information sheet. However, we saw no evidence of PGDs. We raised this with the management and were told that they were in progress and were to be issued in the same week.
- Emergency medicines were available in the event of an anaphylactic reaction. These were in date; however, they were not securely stored or tamper proof.
- Medicines requiring storage were not stored in lockable cabinets, there was a risk of unauthorised access and tamper.
- The centre did not have an on-site pharmacist. Staff told us they could contact a pharmacist if they had any concerns regarding medicines patients were taking.
- Following our inspection, we requested medicines audits from the provider, the centre was unable to provide any.
- The Society of Radiographers (SoR) recommended "Paused and Checked" system was used to check medications prior to administration.

Diagnostic imaging

- Staff were trained on the safe administration of contrast medium including intravenous contrast (IC). We reviewed staff competency files and saw all staff had received this training. We observed one patient receiving IC during our inspection, their allergies were documented and checked on arrival in the unit.
- No controlled drugs were stored and/ or administered as part of the services provided by the European Scanning Centre.

Incidents

- **Staff recognised incidents and reported them. However, the service had no robust systems for reporting incidents and it was not clear how learning from these, was shared or how practice was reviewed.**
- There were no never events reported for the service from September 2017 to August 2018. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- There were no serious incidents reported for the service from September 2017 to August 2018 as defined by the NHS Commission Board Serious Incident Framework 2013. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.
- No duty of candour notifications was made between September 2017 and August 2018.
- There were no IRMER/IRR reportable incidents reported for the service from September 2017 to August 2018. Medical ionising radiation includes x-rays and nuclear scans, and treatments such as radiotherapy. It is widely used in hospitals, dentists, clinics and in medical research to help diagnose and treat conditions. Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) sets out the responsibilities of duty holders (the employer, referrer, IR(ME)R practitioner and operator) for radiation protection. For example: minimising unintended, excessive or incorrect medical exposures ensuring the benefits outweigh the risks of each exposure (justification) keeping doses in diagnostics “as low as reasonably practicable” for their intended use (optimisation) Notifiable incidents under IR(ME)R are those where a dose “much greater than intended” has been delivered to an individual and should be reported to the appropriate authority. Under-doses are not notifiable but must still be locally investigated.
- Senior staff were aware of the requirements for reporting serious incidents to the CQC using the statutory notification route if this met the criteria, under Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.
- Staff told us incidents and complaints were reported verbally to the manager. The service did not have an electronic risk management system. Senior staff told us complaints, litigation, incidents and compliments were discussed in clinical governance meetings. However, these were not minuted, so we could not be assured of this.
- There was a corporate incident reporting policy which detailed Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. However, there was no local policy on incident reporting and procedure in place to guide staff in the process of reporting incidents.
- There was no formal procedure for sharing learning from incidents with staff. Staff told us there were very few incidents at the centre due to the service being relatively small and patients being offered a minimum appointment of one hour. Managers also said the team were a small team and would communicate with each other daily. However, this was not a robust method of managing incidents. Staff told us there was no sharing of incident information between the sites.
- Within CT staff told us they documented adverse effect to cannulation and contrast administration in a small notebook. We were told these were audited and discussed with radiologists, however, we saw no documentation to support this.
- The service was unable to provide external review or local incident investigation report.
- There was no formal process for the analysis of incidents and identification of themes and shared learning to prevent reoccurrence at a local and organisational level. At the time of the inspection, managers told us they would introduce a formal agenda for staff meetings with immediate effect which included incident reporting to prompt staff to report any incidents.

Diagnostic imaging

- We asked the service how National Patient Safety Alerts (NPSA) that were relevant to the centre would be communicated to all staff. The provider informed us that as the service was not an NHS service they did not receive patient safety alerts. Patient safety alerts are issued via the Central Alerting System (CAS), this a web-based cascading system for issuing alerts, important public health messages and other safety critical information and guidance to the NHS and other organisations, including independent providers of health and social care. This meant the provider was not receiving information which could be used to develop guidance to protect patients from harm.
- Staff used The Society of Radiographers (SoR) "Paused and Checked" system. Referrer error was identified as one of the main causes of incidents in diagnostic radiology, attributed to 24.2% of the incidents reported to the CQC in 2014. The six-point check had been recommended to help combat these errors. Pause and Check consisted of the three-point demographic checks to correctly identify the patient, as well as checking with the patient the site/side to be imaged, the existence of previous imaging and for the operator to ensure that the correct imaging modality is used.

Safety Thermometer

- **The service did not complete the safety thermometer as this was not applicable to the service they provided their patients.**
- The service recorded and reviewed daily safety checks, for example: emergency buzzer, intercom, cold head chirping, arrest trolley, temperature and air conditioning.

Are outpatients and diagnostic imaging services effective?

We currently do not rate effective.

Evidence-based care and treatment

- **The service could not be assured it provided care and treatment based on national guidance as there was a lack of systems to monitor evidence of its effectiveness.**
- Patients care, and treatment was delivered in accordance with guidance from the National Institute for Health and Care Excellence (NICE). NICE guidance

was followed for diagnostic imaging pathways as part of specific clinical conditions. However, there was no evidence of monitoring of patient outcomes, except for patient reported satisfaction feedback.

- Staff assessed patients' needs and planned and delivered patient care in line with evidence-based, guidance, standards and best practice. For example, staff followed the MHRA guidelines safety guidelines for magnetic resonance imaging equipment in clinical use. However, there was no annual audit to assess that clinical practice was in accordance with local and national guidance.
- We asked staff about local rules. Staff told us the centre had local rules, however staff were unable to locate them, and they were not displayed within the controlled areas. Safety guidelines from the Medicines and Healthcare products Agency (MHRA), 2015, 4.1.4 'Local rules' state, "It is recommended that the MR responsible person ensures that adequate written safety procedures, work instructions, emergency procedures and operating instructions, are issued to all concerned after full consultation with the MR safety expert and representatives of all MR authorised personnel who have access to the equipment (see section 4.7). Local rules should be reviewed and updated at regular intervals and after any significant changes to equipment."
- MRI local safety rules were in place. We found these were in date and reflected best practice.
- The service carried out some audits, for example appointment waiting times for service, appointment waiting times in department and reporting turnaround times. However, there was no agreed audit system to establish if care and treatment was in line with evidenced based care and treatment.
- We saw no evidence of any discrimination, including on grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation when making care and treatment decisions.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health.**

Diagnostic imaging

- Patients had access to water and hot drinks whilst waiting for their scan. There were facilities in the waiting area for patients to help themselves to tea and coffee. There was also a water dispenser for patients use.

Pain relief

- **Pain assessments were not undertaken at the location.**
- Patients managed their own pain and were responsible for supplying any required analgesia. We were shown a letter patients received prior to the procedure advising them to continue with their usual medications.
- We saw staff asking patients if they were comfortable during our inspection. Staff also asked patients to identify areas where they experienced pain during their scans. This enabled staff to scan areas where patients reported that they suffered pain.

Patient outcomes

- **Managers did not monitor the effectiveness of care and treatment and use the findings to improve them; or compare local results with those of other services to learn from them.**
- Staff informed us that patient reported satisfaction questionnaires were the main method of monitoring patient outcomes. All patients were asked to complete a satisfaction survey following treatment at the clinic. Patients' comments were monitored by the administration manager and there was a system of monitoring results to identify themes and trends. Staff told us 80% of patients completed a patient satisfaction survey following their scan. Data we reviewed showed all patient responses were positive about their experience at the centre.
- The service had an audit schedule. The audits aimed to assist in monitoring the service and drive improvement. It involved all staff ensuring they had ownership of things that had gone well and that needed to be improved. Audits included first aid kits location, knowledge of emergency procedures, patient consent audit, quality of reporting audit – compliance with BTS (British Thoracic Society) guidelines 2015 for reporting on pulmonary nodules on CT, audit on whether ultrasound reports answer the clinical question, patient satisfaction audit, complications post ultrasound intervention, CT heart scan scoring audit and audit on

report turnaround and clinician satisfaction. We were told that all audits were due to commence in the coming months, so we were unable to comment on any data.

- We were told the director of imaging frequently audited reports for accuracy. We saw data recorded to support this.
- Senior management told us blind audits were performed on sample selection of reports to ascertain reporting levels were accurate.
- Patients did not have review appointments scheduled following treatment to discuss their progress and satisfaction following scans. Following our inspection, the centre informed us that MRI scanning services were provided by self-referral from patients, GP or consultant referrers. If patients required further investigations or scans following their initial visit, this would be requested as a separate referral by the GP or consultant.
- There had been no deaths of patients resulting from procedures in the previous 12 months.
- Staff told us there had been no incidents of patients having adverse reactions or side effects to treatment. In the event of a patient experiencing side effects to treatment this would be reported to the centre's manager.

Competent staff

- **All staff received a local and corporate induction and underwent an initial competency assessment.**
- The provider had a local induction checklist which was mandatory for all new staff to complete within two weeks of starting. The local induction ensured staff were competent to perform their required role. The local induction included an introduction to the work location, health and safety, governance and code of conduct.
- Once the probationary period was complete staff were monitored daily and any concerns were brought to the forefront immediately to ensure the correct corporate path was followed. If there were any repeat area of concern, then a more formal discussion took place to ensure their performance was always safe and effective.
- Radiographers' performance was monitored by the operations manager and issues were discussed in a

Diagnostic imaging

supportive environment. Radiologists fed back any performance issues with scanning to enhance learning or highlight areas of improvement in the radiographers' performance.

- All radiography staff were registered with the Health and Care Professions Council (HCPC) and met HCPC regulatory standards to ensure the delivery of safe and effective services to patients.
- Staff had the opportunity to attend relevant courses to enhance the professional development and this was supported by the organisation and the operations director.
- Staff at the service, including non-clinical, had not completed chaperone training. However, staff said they were prepared and confident in chaperoning.
- Data supplied from the service showed 20% of clinical staff had received an appraisal in the 12 months preceding inspection. This equated to one staff member. No non-clinical staff had received an appraisal.
- Senior management told us they did not have a formal in-house annual appraisal for employed members of staff as they were a small, close working team, with an open communications policy. Issues of performance or change were monitored and addressed daily, and team leaders worked closely with senior levels of management for guidance if required. Following our inspection we were told that more staff had appraisals scheduled.
- All radiologists were required to submit annual appraisals from their main employer. Any changes in their NHS lists (i.e. ultrasounds) they no longer do were duplicated at the centre and they were no longer permitted to perform them.
- The service had robust arrangements in place for granting and reviewing practising privileges.

Multidisciplinary working

- **Staff of different kinds worked together as a team to benefit patients.**
- The service had good relationships with other external partners and undertook scans for local NHS providers and private providers of healthcare.
- Staff told us there was good communication between services and there were opportunities for them to contact referrers for advice, support and clarification.

- There was a service level agreement (SLA) for the provision of bloods results from a private laboratory. The service worked well with the private laboratory and relaying bloods results to patients and their practitioners.

Seven-day services

- **European Scanning centre did not provide a seven day a week service.**
- The service operated from 8.30am to 7.00pm on a Monday to Friday.
- Appointments were flexible and could be offered at short notice if required.
- A senior manager was available in an on-call capacity out of usual office working hours

Health promotion

- The provider did not have health promotion information available to support national priorities to improve the populations health. For example: smoking cessation, alcohol awareness and bone health.
- Information booklets such as cardiac imaging, understanding your upright MRI scan were sent to patients with their appointment letters and were available in the waiting rooms. These leaflets included information about the equipment, what the scan would entail and what was expected of the patient before and after the scan appointment. The service's website included this information.
- The service offered well-man and well-woman testing packages.

Consent and Mental Capacity Act

- **The provider could not be assured staff understood their roles and responsibilities under the Mental Capacity Act 2005.**
- Staff had some knowledge of the requirements of the Mental Capacity Act 2005 (MCA). We asked the general manager and operations manager about staff training. The registered manager told us that training in the Mental Capacity Act 2005 was not previously included in mandatory training, however training had been booked in the coming months.
- During this inspection there were no patients that lacked the capacity to make decisions in relation to consenting to their scan. Staff also told us they would encourage patients to be accompanied where there

Diagnostic imaging

were concerns about their capacity to consent. Staff told us they would not make an appointment for a patient where there were doubts about the patient's capacity to understand their care and treatment.

- Staff were aware of the need for consent and gave patients the option of withdrawing consent and stopping their scan at any time. The service used an MRI and CT consent form to record patients' consent which also contained the patients' answers to their safety screening questions.
- Staff were aware of children's consent procedures. Young people (aged 16 or 17) were presumed to have sufficient capacity to decide on their own medical treatment, and provide consent to treatment, unless there was significant evidence to suggest otherwise. Staff were able to tell us about Gillick competence. This is a term used in medical law to decide whether a child (under 16 years of age) can consent to his or her own medical treatment, without the need for parental permission or knowledge.
- We saw that patients were required to complete, sign and date a safety questionnaire which the consenting radiographer would also sign and date. Staff were aware of the need for consent and gave patients the option of withdrawing consent and stopping their scan at any time. We reviewed eight patient care records all included a consent to treatment record.

Are outpatients and diagnostic imaging services caring?

Good



We rated it as **good**.

Compassionate care

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

- In the interactions we saw during this inspection and feedback provided by patients we spoke with, staff demonstrated a kind and caring attitude to patients. Staff explained their role and explained to patients what would happen next.
- During this inspection we spoke with three patients about various aspects of the care they received at the European Scanning Centre. Without exception, feedback was consistently positive about staff and the care they delivered.
- Staff ensured that patients' privacy and dignity was maintained during their time in the centre and during scanning. Patients had designated changing rooms and were provided with a gown if required in the changing room to protect their modesty whilst having their scan.
- To ensure patients were comfortable staff asked patients if they wanted a blanket for warmth and comfort before the procedure and we observed staff checking if patients were comfortable during the procedure.
- Patient satisfaction was measured through completion of the patient satisfaction survey which was sent electronically following their examination. Anonymised responses were analysed weekly and reports and monthly summaries were produced and circulated to the management team. Overall figures were displayed on the centre's website.
- We viewed monthly summaries dated March 2018 to August 2018, and found all patient feedback was very positive about the care and treatment they had received. The operations director told us they monitored patient feedback and used positive comments to praise the staff or in the case of negative comments, the manager would investigate and use the patients' comments to improve the service.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- Staff supported people through their scans, ensuring they were well informed and knew what to expect. Patients were actively invited to visit the centre prior to their scan to allay any anxieties they may have about the scanning procedure.

Diagnostic imaging

- Staff provided reassurance and support for nervous, anxious, and claustrophobic patients. They demonstrated a calm and reassuring attitude so as not to increase patients' anxiety.
- We observed the staff provided ongoing reassurance throughout the scan, they updated the patient on how long they had been in the scanner and how long was left. Patients also had a panic button they could press any time during the scan to summon help. Staff could stop the scanning immediately if the patient requested this.
- The centre's staff felt that recognising and providing emotional support to patients was an integral part of the work they did. The service specialised in providing scanning to anxious and phobic patients. Staff recognised that scan-related anxiety could impact on a patient's scan and this could result in possible delays with the patient's treatment.
- The centre had an up to date chaperone policy. Patients were asked at the time of booking if a chaperone was required.
- Family members or carers were able to accompany patients that required support into the scanning area.
- Patients could bring their own choice of music to listen to during the scan which was played through headphones. This helped to disguise the noise the scanners made which could cause anxiety for some patients. Earplugs were also available which protected their ears and helped to reduce the noise.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them about their care and treatment.**
- We observed when staff checked through the patient's safety questionnaire, patients were given an opportunity to ask questions.
- The service allowed for a parent or family member or carer to remain with the patient for their scan if this was necessary.
- Staff recognised when patients or relatives and carers needed additional support to help them understand and be involved in their care and treatment. Staff enabled them to access this, including access to interpreting and translation services.

- Patients and relatives and carers could ask questions about their scan. Patients could access information on upright MRI scanning from the company's website. However, there was a wide range of information available to patients in the centre.
- Patients were provided with an information leaflet when they received confirmation of their appointment. This explained the differences between upright and conventional MRI scanning. Staff also gave patients information on preparing for a scan and what they should bring with them to their scan, including referral letters and medical insurance details if applicable. The leaflet also advised patients on what to wear to their scan, for example, patients should not wear clothing with metal fasteners or under wiring. The leaflet also informed patients of contra-indications and that these should be discussed with staff prior to an appointment, including tattoos and piercings.
- Patients were informed of when they would receive their scan results; there were clear expectations and the service met their timely goals.

Are outpatients and diagnostic imaging services responsive?

Good 

We rated it as **good**.

Service delivery to meet the needs of local people

- **The service planned and provided services in a way that met the needs of local people. Facilities were appropriate to patients' needs.**
- The service provided upright MRI, CT, EOS and ultrasound scanning. The centre provided scans through contractual agreements with two NHS trusts and a private insurer. For privately funded patients, the service was appropriate and sensitive when having conversations about cost. Patients reflected this and said there were no surprise additional costs and all payment of services was handled well.
- The service had a good understanding of the needs of the local population. The service provided a flexible service with good choice of appointment times. One

Diagnostic imaging

patient told us they found the service on a search engine, was given a choice of time slots including the next day and had a short wait on the day of the scan. We were told the booking process was efficient.

- We were told the service accommodated patients at the earliest convenience and ensured results were turned around within the stated turn-around time of 24 - 48 hours. Referrers were given the facility of IEP (image exchange portal) to enable remote access and a quicker process. Reports were securely emailed via egress to avoid any postal delays. For some scans same day and for some doctors a walk-in service was offered to accommodate the needs of their patients.
- All patients had to provide their GP details prior to any scan. This meant the service could always notify the relevant healthcare professional should there be any urgent findings.
- The environment was patient centred warm and welcoming. The European Scanning Centre was located in a building which was shared with a residential flat on the third floor. The unit had comfortable and sufficient seating in reception areas. Toilets and drinks were available to patients and visitors in the main reception waiting area.
- The service provided services for a range of patients, however it was recommended patients with reduced mobility were referred to another location.
- The service was accessible through established bus and train routes. There was a bus stop and a train station within a short walk. Patients were also able to use car parking on Harley Street. Patients would have to pay the congestion charge in addition to parking costs.
- Information was provided to patients in accessible formats before appointments. Appointment letters containing information required by the patient such as contact details, a map and directions, health professional's name if appropriate, and information about any tests or intervention including if samples or preparation such as fasting was required. The appointments letters sent out, asked patients to call in if they had any queries or if they had answered yes to any of the questions on the MRI safety questionnaire.
- All appointments were confirmed two days prior to patient's appointment, by phone. This helped reduce the number of do not attend (DNA's) and provided an opportunity for the patient to ask us any questions they may have. Should a patient not be verbally contacted

prior to their appointment, for example where a message is left for the patient on an answer machine, the patient was asked to call the service to confirm their intention to attend the appointment.

Meeting people's individual needs

- **The service took account of patients' individual needs.**
- The service had an open upright MRI scanner which enabled patients who are larger in build, or claustrophobic or unable to tolerate closed MRI scanners a method of imaging. Patients that were less able to cope with stairs had access to a chair lift to the basement.
- When necessary, patients had access to an interpreter before going ahead with scans. Interpreters would be booked by the administration manager for the time of the patient's appointment.
- The CT scanner had key commands in a selection of languages to assist in the patient's understanding of what was required of them to complete the scan. We were told the service was expanding the range to include Arabic soon.
- Within both MRI and CT, the patient had the choice of listening to their own style of music which contributed to their overall experience.
- The service offered a chaperone facility on patient request, however, staff at the centre had not had chaperone training. Relatives or friends attending with patients were encouraged to stay with the patients up until their scan to help with any levels of anxiety.
- During scans, staff made patients comfortable with padding aids. Patients were given an emergency call buzzer to allow them to communicate with staff should they wish. Microphones were built into the scanner to enable two-way conversation between the radiographer and the patient. Patients could bring in their own music for relaxation. A relative or carer could be present in the scan room if necessary and after they had been screened for safety.
- The CT EOS was beneficial for the study of scoliosis in children. Parents or guardians were encouraged to enter the room also during these scans.
- The centre made it clear to patients that they could not be responsible for any child that attends with an adult having a scan. However, the centre provided books and jigsaws to assist in entertaining the child.

Diagnostic imaging

- Following their examination, patients were given an explanation on aftercare. For example, cannulation sites and hydration. Patients were also provided with a copy of their scan results on compact disc (CD).

Access and flow

- **People could access the service when they needed it.**
- The administration team received enquiries via phone, email, post and fax. They would print and obtain 'sign off' from the relevant scanning department. The patient would then be called to arrange a mutually agreeable day, and time. Consideration was given to whether a follow up appointment was known. The booking was then made on the radiology information system (Ris) and the letter of referral was scanned and attached along with any payment details or supplementary letters. If the service could not for any reason accommodate same day, then the next available appointment was offered.
- All the referrals were triaged by the clinical radiographic staff that reviewed and confirmed suitability of location for patients. For complex cases the clinical radiographic staff could seek assistance from the consultant radiologist team.
- The centre did not have a waiting list. However, for the NHS trusts who sent through bulk bookings to be made, the appointments were booked in based on when the patients follow up appointments were arranged for.
- Between July 2017 to July 2018, there had been no procedures/examinations cancelled for a non-clinical reason. During the same period four procedures/examinations were delayed for a non-clinical reason, the most frequent reason for delay was due to MRI breakdown.
- Appointments generally ran to time; reception staff would advise patients of any delays as they signed in. Staff would keep patients informed of any ongoing delays.
- The registered manager reported it was very rare for private patients not to attend their appointment. If NHS patients did not attend (DNA) the centre would contact the patient and offer them another appointment. After two DNA's the patient would be referred to their referring consultant/doctor.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously.**
- The services complaints policy was available on the website and within the General Data Protection Regulation (GDPR) policy which all patients read before they were scanned. We saw details of the policy within the statement of purpose which we saw located within the waiting room upstairs and waiting area downstairs.
- The policy informed the patient on how to make a complaint. The administration manager initially dealt with all complaints. The operations director would then be informed, and other members of the team were included if appropriate as part of any investigation. If a written complaint was received it was dealt with by the operations director who would conduct a full investigation. The medical director would then be briefed, and a written response would be sent back to the complainant.
- The service received three complaints and 28 compliments between October 2017 and September 2018. All three complaints were dealt with under the formal complaints procedure in accordance with the service's timescales. None were upheld.
- Senior management told us the service discussed patient feedback and informal complaints at team meetings. However, we were unable to see evidence of this as these meetings were not minuted.

Are outpatients and diagnostic imaging services well-led?

Requires improvement 

We rated it as **requires improvement**.

Leadership

- **Managers had the right skills and abilities to run a service providing high-quality sustainable care.**
- Leaders had the skills, knowledge, experience and integrity needed both, when they were appointed and on an ongoing basis.
- The centre was managed by a medical director, who was the nominated individual and chairman of the

Diagnostic imaging

board. They were supported by an operations director who was the registered manager and administration manager. The management team also managed another of the provider's services in Manchester.

- We saw that managers had completed 'fit and proper' persons checks to ensure that staff were of good character, had the right competencies, skills and were physically and mentally fit for their role.
- Staff had specialist lead roles within the centre. For example, the MRI lead radiographer was the lead for safeguarding and infection prevention and control (IPC). Staff were supported by additional training to fulfil these specialist lead roles.
- Staff told us the manager was visible and approachable and they could contact them at any time by phone or email when they were not on-site. Staff said both the operations manager and the medical director were approachable and supportive. All the staff were positive about the management of the service.
- The service supported staff to develop within their roles. Staff said the centre was committed to the continuing development of staff and offered access to both internal and externally part funded training programmes to support staff in developing skills and competencies relevant to their career with the European Scanning Centre.
- Leaders of the service were open and transparent. When they did not know something, or were not sure if they had documentation, they told us this and made efforts to provide all evidence. Leaders were passionate about the service and providing patients with a safe, quality experience.

Vision and strategy

- **The service did not have a vision for what it wanted to achieve**
- Staff were not aware of any plans to develop the service.
- Staff told us the company did not have any values which staff behaviours should be aligned to. Although requested, the company business plan was not made available to us on inspection. Staff told us the strategy within the business plan was based on a financial business model and did not address how clinical outcomes would be measured or monitored.
- Before our inspection we requested the service's quality accounts through our routine information request.

Quality accounts are annual reports about the quality of services provided by a service. The centre did not provide a quality account, we were therefore unable to form any judgements about the quality of services.

- We were told that strategies to support business growth and sales were discussed within team meetings. However, the meetings were not minuted or recorded and there was no agenda or action log available. We could therefore not be assured.

Culture

- **Managers promoted a positive culture that supported and valued staff. However, the provider could not be assured that there was an embedded culture of communicating regarding incidents and complaints.**
- Staff told us they felt supported, respected and valued by the organisation. Staff told us they felt proud to work for the organisation. All staff were very happy in their role and stated the service was a good place to work. All staff talked about the very supportive staff team.
- The service's culture was centred on the needs and experience of patients. This attitude was reflected in staff we spoke with on inspection.
- Staff said they felt well supported in their roles and would be able to challenge practice or raise concerns regardless of role or seniority if necessary. There were clearly defined management structures, however, staff told us they felt able to approach leaders across professional boundaries.
- Staff told us team meetings were held regularly. However, there was no set schedule or terms of reference for the meetings. We were told that meetings were not minuted. There was no action log, and management told us that staff were responsible for completing actions discussed within the meeting. There was no process to follow this up. Managers confirmed that incidents and complaints were discussed at team meetings, however we were unable to see evidence to support this. Staff told us there was no shared learning of incidents and complaints between the other locations.
- Staff told us there was no time allocated to continuous professional development (CPD). There were no journal clubs set up and staff were expected to carry out CPD within their own time.

Diagnostic imaging

- The service promoted equality and diversity, it was part of mandatory training, inclusive, non-discriminatory practices were promoted.
- A whistle blowing policy and a duty of candour policy supported staff to be open and honest.
- All independent healthcare organisations with NHS contracts worth £200,000 or more are contractually obliged to take part in the Workforce Race Equality Standard (WRES). Providers must collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality. The service did not have WRES report.
- There was a system in place to ensure non-NHS funded people using the service were provided with a statement that included terms and conditions of the services being provided to the person and the amount and method of payment of fees.

Governance

- **The service did not use a systematic approach to continually improve the quality of its services.**
- Progress in the quality and safety of services was not monitored through key performance indicators (KPI), performance dashboards or reports that enabled comparisons and benchmarking of patient outcomes and risks with other services. Although, some data was collated this included the patient satisfaction survey and a finance spreadsheet. This gave the provider information on the centre's financial performance and patients satisfaction with services received.
- Management told us local governance processes were achieved through monthly team meetings and local analysis of performance and discussion of local incidents. Feedback and actions were fed into processes at a corporate level. We were unable to see evidence of this process as meeting notes were not taken or recorded.
- Staff were clear about their roles and understood what they were accountable for. All clinical staff were professionally accountable for the service and care that was delivered within the unit.
- Staff working with radiation were provided with appropriate training in the regulations, radiation risks, and use of radiation. However, it was not clear if staff were aware of the changes made by the introduction of the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER17) which had been introduced in February 2018.

- There were processes in place to ensure staff were fit for practice, for example, they were competent and held appropriate indemnity insurance in accordance with The Health Care and Associated Professions (Indemnity Arrangements) Order 2014.
- Working arrangements with partners and third-party providers were managed. There were service level agreements between the service and the acute trust, the clinical commission group and a private insurer provider. The service did not have quality reports and regular meetings to discuss the service provided.

Managing risks, issues and performance

- **The service did not have robust systems to identify, record and manage risks.**
- The European Scanning Centre had a corporate risk register which identified four risks. It was unclear how these risks were monitored or when they were last reviewed. There was no local risk register.
- None of the risks identified during the inspection regarding safeguarding or medicines management were included on the risk register.
- The centre did not have formal MRI safety meetings which did not reflect best practise. The provider told us this was included as part of the monthly meetings but there was no standing agenda or minuted meetings, we were therefore not assured.
- There was a lack of local audit and no formal peer review of scans for quality and accuracy which meant ESC were not able to easily identify what areas of practice and performance needed to be reviewed or improved.

Managing information

- **The service used secure electronic systems with security safeguards.**
- Electronic patient records could be accessed easily but were kept secure to prevent unauthorised access to data.
- Staff told us there were sufficient numbers of computers in the unit. This enabled staff to access the computer system when they needed to.
- Staff training on information governance was part of the provider's mandatory training programme.

Diagnostic imaging

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

Engagement

- **The service engaged well with patients and staff to plan and manage appropriate services.**
- Staff satisfaction surveys were not undertaken. Managers told us due to the relatively small number of staffs a staff survey would not be meaningful. Managers told us they engaged with staff daily and felt staff were able to raise any concerns without fear of reprisal.
- Patients' views and experiences were gathered and acted on to shape and improve the services and culture. Patient surveys were in use, the questions were sufficiently open ended to allow people to express themselves. We saw changes were implemented following feedback from patients.
- Staff meetings were held monthly, however minutes were not taken at these meetings. We were unable to comment on the content or efficiency of these meetings.

- The service had service level agreements (SLA) with two NHS trusts for the provision of CTCA (CT coronary angiography) and EOS scans.

Learning, continuous improvement and innovation

- **The service was committed to promoting innovative approaches to patients care and treatment.**
- The team were proactively improving care for patients using the service. The service had recently reviewed the clinical teams and employed an additional radiographer, this was to provide clinical support to the team.
- The centre had a standardised protocol for CTCA (CT coronary angiography) reporting and are the only independent provider with access to this software.
- The centre performed more than 2000 CTCAs each year and had an established team of experienced level 3 accredited cardiac imaging specialists.
- The centre had comprehensive business continuity plan.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure staff are trained in the Mental Capacity Act 2005 and aware of their responsibilities under this Act.
- The provider should ensure there is learning from incidents are shared and practise reviewed.
- The provider should have robust arrangements for identifying, recording and managing risks.
- The provider should ensure a medicines audit is completed.
- The provider should have a systematic programme of clinical audit to monitor quality or systems to identify where action should be taken.
- The provider should collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality.
- The provider should schedule skills or drills training for the evacuation of a patient from the MRI scanner.
- The provider should ensure all sharps disposal bin labels are correctly completed.
- The provider should conduct internal hand hygiene and cleanliness audits.
- The provider should consider the location of the resuscitation equipment within the centre and ensure equipment and medication is tamper proof.
- The provider should ensure all staff have annual documented appraisals.
- The provider should implement an audit system to establish if care and treatment was in line with evidenced based care and treatment.