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Department **QS Enterprises**		**Team/Specialty** **Radiology**		
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Document Revision History			
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3.0	24/10/2019	24/10/2020	• Addition for sub-speciality roles in Section 5.1 • Addition of operational structure with lines of accountability in Appendix 1.
4.0	01/04/2020	01/04/2021	• 3.0 – Addition of medical devices • 5.1.8 – Addition of First Aid Link Staff • 5.1.9 – Addition of IV Access Link Staff • 6.0 – Hours of Operation amended • 9.0 – Imaging portals added • 15.0 – Pacemaker and Medical Devices SOP
5.0	04/10/2021	31/10/2022	• Update to subspeciality link post holders • Addition of ANTT to Infection Control link role duties (5.1.6) • Addition of safer handling link staff 5.1.11 • Addition of new SLA with UCLH biomedical engineering (7.0) • Section 14.0 amended (pregnancy) to signpost to new local rules and employer's procedures documents for each modality. • New Section (16.0) for patient safety in CT.
6.0	30/06/2022	01/06/2023	• 2.0 – Addition of MRgFUS • Updates to names and email addresses of link staff. • 9.0 – Core staff numbers added to section
7.0	29/09/2022	29/09/2023	• Updates to Post Holders/ Leads • Including new Sub-Speciality Leads

8.0	13/06/2023	01/06/2024	• Updates to sub-specialty roles due to staff turnover. • Addition to Mental Health First Aid role to Section 5. • Addition of REALM to communication and meetings structure (Section 6 and Appendix 2) • Workforce updated in Section 9.
9.0	13/06/2024	03/06/2025	• 5.1.6- change in personnel
10.0	14/08/2024	14/08/2024	• Changes to personnel. Updated radiology service organisational chart. • Change Management included
11.0	23/06/2025	01/06/2026	• Updates to named employees in sub-specialty roles (5.1) • Updates to workforce planning number in Section 9 to reflect new roles. • Organisation chart in Appendix 1 updated
12.0	09/06/2026	01/06/2027	• Annual review. Updated named post holders, workforce planning information, quality governance arrangements, reporting pathways and organisational details. Reviewed against current operational practice and related QSE policies. • Addition of Cybersecurity and risk management sections.

Equalities Impact Statement

The author of this policy has undertaken an Equality Impact Assessment (included at the end of this document) and has concluded that there is no negative impact on any protected equalities groups.

1.0 Summary

This document describes the management system and structure for QS Enterprise Ltd's (QSE) diagnostic imaging services.

The Quality Manual outlines the requirements and expectations for the services and staff within QSE's imaging facilities in performance and delivery of a high-quality service which is compliant with applicable legislation, regulatory requirements, professional guidance and recognised imaging quality standards.

It outlines the operating practices of the service and includes details on service staffing, equipment, environment, risk management and performance management information.

This document will be reviewed and approved on an annual basis by the QSE Governance team.

2.0 Introduction

QSE provides Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) services to private outpatients, private inpatients, NHS outpatients and research subjects across two diagnostic imaging facility sites; the Queen Square Imaging Centre and Chenies Mews Imaging Centre.

In June 2022, the Company installed an Exablate system to support the provision of MR-guided focused ultrasound treatment in collaboration with the functional neurosurgery team at the National Hospital for Neurology and Neurosurgery.

In addition to their professional duties relating to the provision of diagnostic imaging examinations, the Company's dedicated radiology staff will:

- Ensure the safety and protection for all staff, patients, and visitors.
- Manage an efficient administration pathway for diagnostic imaging referrals.
- Issue verified radiology reports from the consultant radiologists and cardiologists who have practising privileges with the organisation in an efficient manner in accordance with Company's targets.
- Ensure a safe and caring environment for all staff, patients, and visitors.

2.1 QSE Management Commitment

Management is committed to the establishment and implementation of the quality management system and continual improvement. This is demonstrated as follows:

- A Quality Manual which defines responsibilities, authorities and interrelationships of all personnel and describes meeting purpose and structure.
- Key points from the manual are extracted and communicated/displayed around the department to inform staff of our commitment and compliance to quality standards.
- An established meeting structure with agreed terms of reference which serve requirements for communication and escalation.
- An annual plan which details SMART objectives for Radiology services which takes account of the needs and requirements of service users.
- Management review (held annually as a minimum) of the Quality Manual.
- Interaction with users through multidisciplinary forums and performance of stakeholder surveys to monitor satisfaction with current service provision and identify improvements/user requirements.
- Staff assessment against technical competency requirements as appropriate and participation in individual performance reviews in the form of an annual appraisal.

3.0 Objectives

This Quality Manual aims to promote the delivery of a high quality, efficient and effective Radiology service by providing the QSE Radiology team with operational guidance relating to:

- Specific roles and responsibilities
- Hours of Operation and workforce planning
- Information Governance and administration of imaging records.
- Administration of Radiology Reports (including urgent findings)
- Patient Identification
- MRI and CT Safety (including pregnancy and medical devices)
- Radiographic Equipment, Fault Reporting and Contingency Planning
- Sickness and Absence
- Training, Development and Study Leave
- Administration of requests

4.0 Scope

This Quality Manual applies to all radiology staff working for QSE, whether they be permanent or temporary staff.

5.0 Duties and Organisational Structure

All radiology staff, including managers, radiographers, Health Care Assistants, and temporary staff have duties under this Quality Manual. The basic structure of the Company's imaging services including information about the operational and professional lines of accountability and details of the various professional roles within this structure is outlined in Appendix 1. Details of the wider organisation structure may be found in the QSE Statement of Purpose document.

In addition to their core role, many staff will also be expected to assume responsibility for a subspeciality and provide specialist input and guidance to their colleagues and the multi-disciplinary team in the specific subject matter.

All new staff should be made aware of this Quality Manual as part of their formal induction.

5.1 Sub-Specialty Roles

5.1.1 MRI Safety Officer

The superintendents of each site will receive specific training in order to form a cross-site MR safety group. Chaired by the operations manager and supported by a nominated MR Safety Expert/Safety Advisor from UCLH, this group will be responsible for the development of suitable working practices as outlined in the **Local Safety Rules** to ensure both the safe operation of the scanners and the personal safety of all persons involved in the scanning operation. These working practices will comply with the guidance issued by the National Radiological protection Board (NRPB), the Department of Health on the safety of diagnostic equipment and the British Association of MR Radiographers. To support the Superintendent Radiographers, senior radiographers in each department will receive training support to attend the MRSO course each year.

Post Holders:

QSIC (MRI)	Eleonora Giankou	egiankou@queensquare.com
CMIC (MRI)	Kim Le	kle@cheniesmews.com

5.1.2 Modality Clinical Specialist

Typically, the superintendent or a staff member nominated by the operations manager owing to their level of experience, the modality clinical specialist will take responsibility, as delegated by the

superintendent, for leading the cross-modality team and be responsible for an area of the day-today clinical service.

They will work closely with senior management and, where applicable external consultants to lead a high quality, adaptable and effective imaging service, ensuring that all applicable legislation and Company Policy is adhered to. Their role will require them to take ownership of clinical audit, risk management and staff management activities relating to their subspeciality area.

Post Holders:

QSIC (CT)	Trent Sparks	tsparks@queensquare.com
MRgFUS	Triona Dewar	tdewar@queensquare.com

5.1.3 Quality and Safety Lead

The operations manager is the quality and safety lead for the Company, representing the radiology service at Company meetings where quality, patient safety and performance improvement are discussed. The lead will develop, monitor and sustain a quality and safety programme centred around patient safety, process improvement, assessment of outcomes and patient satisfaction, promoting a culture of safety and quality across both imaging sites in accordance with Company values. This programme will utilise staff members in sub-speciality roles to develop a mechanism for data collection, interpretation, and presentation so that key performance indicators may be reported and discussed on a regular basis at team meetings. In their absence, the CEO and Departmental Leads will perform this role.

As part of this role, they will sit on the Queen Square Division Clinical Governance Committee of the National Hospital for Neurology and Neurosurgery.

Post holder:

Peter Sutton	psutton@queensquare.com
Jodee Cooper	jcooper@queensquare.com

5.1.4 Governance Lead Radiographers

The governance lead radiographers work alongside the Quality and Safety Lead to take a leading role in the delivery of quality and governance programmes across both imaging sites, ensuring that services are safe and well led. They take primary responsibility for the development, review, and compliance with the **Incident Reporting Policy**, organising After Action Reviews and for the coordination of the **Operational Risk Register**. They also take a leading role on the development and implementation of QSE accreditation standards for QS Enterprises.

Post holder:

Kim Le	kle@cheniesmews.com
Eleonora Giankou	egiankou@queensquare.com

Carol McGann	cmcgann@cheniesmews.com

5.1.5 Adult Safeguarding and Child Protection Link Staff

All clinical staff are required to complete safeguarding training appropriate to their role and level of patient contact, as defined in the Company's Training Needs Analysis. The Company also requires that one permanent member of staff at each site receives Level 4 training in Adult Safeguarding and Child Protection so that they may act as adult safeguarding and child protection link staff between QSE employees and the safeguarding infrastructure of our partner organisation, the UCLH Trust. They will undertake additional training, attend events and training sessions on the subject and take part in regular safeguarding and child protection committee meetings which are chaired by the Operations Manager. They will present safeguarding and Child protection updates at team meetings on a regular basis and take part in the review of the Company's **Child Safeguarding and Protection Policy and Adult Safeguarding Policy.**

Post holders:

QSIC	Crishna Parmar	cparmar@queensquare.com
CMIC	Ruby Wain	rwain@cheniesmews.com

5.1.6 Infection Control, ANTT and Hand Hygiene Link Staff & IPC Lead

Several staff members are nominated by the Quality and Safety Lead to act as a cross-site Infection Control and Hand Hygiene Link Staff Members. They take responsibility for annual infection control audits in each location and for monitoring compliance with ANTT practice and monthly hand hygiene compliance audits. They will undertake risk assessment at both sites and routinely report back to the Quality and Safety Lead to develop action plans for service improvement and risk mitigation. They will also present infection control updates and refresher training as required at team meetings and advise on the review of the Company's **Infection Control Policy**. One member of staff will be nominated as the IPC Lead.

Post holder:

Rebecca Taylor	rtaylor@queensquare.com
Shane Palmer- IPC Lead	spalmer@cheniesmews.com

5.1.7 Patient Emergency Response and Resuscitation Team (PERRT) Link Staff

QSE is privileged to be able to utilise the expertise of the UCLH Trust's dedicated PERRT, who provide the Company and both imaging facilities with all mandatory training, guidance on resus equipment and consultancy support for resuscitation simulations and real-world situation debrief. This service is provided via a Service Level Agreement between each separate site and the PERRT team.

To support this process, QSE nominates one permanent cross site staff member to act as a PERRT link staff member. This person will develop, monitor, and sustain an internal programme for patient

emergency response, including regular resuscitation simulations using a range of scenarios, learning from After Action Review and Risk assessment and management. They will present learning outcomes at monthly team meetings and advise the Quality and Safety lead on matters relating to emergency response.

Post holder:

Eleonora Giankou	egiankou@queensquare.com

5.1.8 Fire Wardens

It is mandatory for all staff to undertake fire safety awareness training as highlighted in their training needs analysis. All staff must be familiar with, and able to act in accordance with their **Local Fire Safety Policy (QSIC and CMIC)**

At each clinical site, dedicated fire wardens are selected for additional training so that they may assist in the response to fire alerts and assume further responsibilities for the safety of the occupants of their area.

Post Holders:

QSIC	Joel Isaacs	jisaacs@queensquare.com
CMIC	Kim Le	kle@cheniesmews.com

5.1.9 Nominated First Aiders

At each clinical site, dedicated first aiders are responsible for the upkeep and application of the first aid equipment kept on each site. They will undergo additional Level 2 First Aid at Work training to provide up to date guidance on first aid in the workplace in line with the **QSE Health and Safety Policy.**

Post Holders:

Kim Le	kle@cheniesmews.com
Trent Sparks	tsparks@queensquare.com

5.1.10 Nominated Mental Health First Aider

The company has nominated a dedicated mental health first aider, who shall be responsible for the provision of mental health first aid to staff across all sites. They will undergo formal Mental health First Aid training to provide up to date guidance on mental health first aid in the workplace in line with the **QSE Health and Safety Policy.**

Post Holders:

Kim Le	kle@cheniesmews.com

5.1.11 Intravenous (IV) Cannulation Link Staff

As it is a requirement of our clinical working practice to carry out IV cannulation on many of our patients, it is important that practice is monitored and audited regularly. Link staff will coordinate these activities and report to the **Quality and Safety Lead** and refer to the **Mandatory Training Policy** to ensure good clinical practice is being adhered to and training requirements are fulfilled.

Post holder:

Carol McGann	cmcgann@cheniesmews.com

5.1.12 Pacemaker MRI Coordinator

QSE recognises the clinical importance but also the inherently higher risk of providing an MRI scanning service to patient with implanted cardiac devices. To support the company and functional team in promoting safety, clinical effectiveness and good practice, the Company has nominated a dedicated lead radiographer for the pacemaker service at Chenies Mews, who will oversee service provision at a local level, manage associated risk assessment and monitoring activities.

Post holder:

Shane Palmer	spalmer@cheniesmews.com

5.1.13 Paediatric Lead

The Company performs very few paediatric scans, and only at the Chenies Mews Imaging Centre site. In recognition of the need to ensure patient safety, suitability and proper communication and information, the Company has a nominated Paediatric Lead. This lead is responsible for all aspects of paediatric imaging at CMIC. The post holder will be responsible for ensuring the Company is complying with National and local guidelines for the imaging of children and young people, including auditing our processes.

Post Holder:

Kim Le	kle@cheniesmews.com

5.1.14 Education Lead

The Company recognises that providing learning and development opportunities as part of continuous professional development (CPD) for all staff at every level, will help build organisational effectiveness as well as enabling staff to achieve personal and career goals. The Company also recognises the need to support activities that ensure that all staff can meet the requirements of their continuous professional development. The Company has therefore nominated an Education Lead who is responsible for reviewing induction and competency training, providing a mentoring role for new employees, along with reviewing the Training & Development Policy, along with the CEO and Operations Manager.

Until the post is filled, these responsibilities will be overseen by the Operations Manager and Superintendent Radiographers.

5.1.15 Intraoperative Imaging Lead- MRgFUS

The Company has introduced a new MR Guided Focused Ultrasound service working in collaboration with the Functional Neurosurgery team of the National Hospital for Neurology & Neurosurgery. QSIC performs the pre-assessment scanning (CT & MR) and on the day of treatment, the MRI scanner is used for lesion location. The Company has nominated a lead radiographer to work closely with the Neurosurgery team for each treatment. They are also responsible for developing sequences as and when required by the team.

Post Holder:

Triona Dewar	tdewar@queensquare.com

5.1.16 Research Lead Radiographer

The Company undertakes numerous research projects for a variety of institutions. These projects are predominately scanned at Chenies Mews Imaging Centre. There is a nominated Lead Radiographer who is responsible for co-ordinating these projects from the first initial enquiry to execution of the project. In practice, they work with various members of the team to perform a feasibility review, a costing review and allocation of scanner time.

Post Holder:

Carol McGann	cmcgann@cheniesmews.com
Shane Palmer	spalmer@cheniesmews.com

6.0 Communication and Meeting Structure

QSE operates a quality governance framework designed to provide assurance that radiology services are safe, effective, responsive, well-led and continuously improving. This framework includes incident reporting and learning, risk assessment and risk register review, clinical audit, patient feedback, complaints review, performance monitoring, equipment quality assurance, staff training and competency review, policy review, and escalation through the Company's governance meeting structure.

Findings from audits, incidents, complaints, patient feedback, risk assessments and external reviews are reviewed through the Quality, Safety and Clinical Risk Management Subcommittee and relevant staff meetings. Actions are recorded, allocated to named individuals, monitored to completion and reviewed for effectiveness.

To ensure good governance, QSE employs an overarching meeting structure that is designed to minimise layers of reporting. All staff are expected to actively participate in meetings as a critical component of the organisation's operations as well as an important aspect of development of individual staff members. The following formal meeting structure is designed to minimise the layers

of reporting and is continually evolving. Meetings and group which are not yet formalised or are of a temporary nature are not included here.

Meeting	Purpose	Attendees	Occurrence
QSE Board of Directors Business and Strategy	To discuss and communicate strategic items of interest to the Board. To discuss and communicate operational issues for the Business team	QSE Board of Directors CEO Finance Manager Operations Manager Other attendees by invitation	Bi-Monthly
NHNN Consultants Meeting	To discuss and communicate medical workforce items and to update the medical workforce on QSE departmental items	Clinical Lead for QSE Consultant Radiologists Other attendees by invitation	Monthly
NHNN Radiology Events and Learning Meeting (REALM)	To discuss radiology events and discrepancies anonymously alongside examples of excellence. Examinations acquired by QSE are selected for review during this external meeting.	Chair (Dr Dumba) Consultant Radiologists (including all those with QSE Practising Privileges) Radiology trainees and students	At least 6 meetings per year

QS Division Clinical Governance Committee	To discuss and communicate matters relating to the UCLH Trust and NHNN's Clinical Governance Framework. QSE Operations Manager invited to observe.	QSD/NHNN Department Leads Clinical Leads Quality Managers Unit Coordinator QSD divisional management (QSE attendance by invitation)	Monthly
QSE Medical Advisory Committee	See MAC Terms of Reference		Bi-Annual
Departmental Management Forum	To review, discuss and communicate performance across all functional areas. Identify areas and actions for improvement. To discuss forthcoming local/regional/National challenges and opportunities	Senior Management team Lead Radiographers Radiology Administration Managers Private Consulting Rooms Manager	Bi-Monthly
QSE Quality, Safety and Clinical Risk Management Subcommittee	Quality group to oversee departmental quality programme and maintenance of Quality Management System, including regulation and accreditation. See QSCRM Terms of Reference for full details.	Operations Manager Lead Radiographers Governance Lead Radiographer Sub-Speciality Leads (as described in section 5.1)	Monthly

MR Safety Group	Reports to QSE Quality and Safety Group. Oversees all MR Safety activity. Input from UCLH Medical Physics and ensures regulatory compliance. See MRSC Terms of Reference for full details.	Lead Radiographers Operations Manager Medical Physics Expert/MR Safety Advisor (UCLH)	6 months
Radiation Protection Advisory Committee	Responsible for maintaining compliance with legislation and best practice regarding the use of ionising radiation within QSE facilities. These responsibilities relate to patients, staff, contractors, visitors, the public and the environment. See RPAC Terms of Reference for full details.	Radiation Protection Advisor (RPA) – UCLH Radiation Protection Supervisor/CT Clinical Lead QSIC Superintendent Operations Manager	6 months
Radiographer Staff Meeting (Cross-site)	Updates staff regarding any service changes and engages staff in decision making. Forum for discussion of concerns and learning outcomes. Forum for Patient Experience Subcommittee	Operations Manager/CEO Lead Radiographers Governance Lead Radiographer Senior Radiographers RDA	Monthly or as requested
Administration Staff Meeting (Cross-Site)	Updates staff regarding any service changes and engages staff in decision making. Forum for discussion of concerns and learning actions. Forum for Patient Experience Subcommittee	Operations Manager/CEO Administration Managers Administration Staff RDA	Monthly or as requested

Superintendent Forum	Forum for discussion of concerns and learning actions, strategic decision making and review of operations.	Superintendent Radiographers Operations Manager	As requested,
Individual Staff 1:1's	Opportunity for discussion of individual issues and exchange of ideas. If required, issues reported to lead managers or team meetings	All staff	As requested,

6.1 Audit Programme and Effectiveness Monitoring

Audit forms a critical part of QSE's quality management system and provides assurance that radiology services are being delivered safely, effectively and in accordance with relevant policies, procedures, regulatory requirements and recognised standards. Audit activity is used to monitor compliance, identify areas for improvement, support learning, and provide evidence of continual improvement across the service.

Details of the audits undertaken by QSE, including audit schedules, responsible leads, frequency, reporting routes and completion status, are maintained within the QSE Audit Policy and Audit Masterlist, which are available to staff on the shared drive.

7.0 Contracts and Service Agreements

Contracts or service level agreements are essential for service provision. Where a service is provided by QSE to another party, a QSE SLA is in place. Where a service is provided to QSE by another party, a contract or SLA will be in place.

Operational relationships with key stakeholders external to QSE are as follows:

Operational relationship with…	**Nature of relationships/agreement/interaction**	**Supporting Evidence**
National Hospital for Neurology and Neurosurgery Lysholm Department for Neuroradiology	• Neuroradiology reporting of QSE imaging by consultants of the National Hospital for Neurology and Neurosurgery • Provision of NHS service by QSE for the NHNN • Provision of medical scientist support by NHNN for QSE's fMRI service	SLA held by NHNN.
UCLH Trust PERRT Team	Provision of resuscitation policy, training, and equipment to the QSE Queen Square Imaging Centre and Chenies Mews Imaging Centre	SLA held by UCLH NHS Foundation Trust
Clinigov Solutions Ltd	Provision of independent pharmacy consultancy to QSE	SLA held by QSE.
UCLH Medical Physics Department	Provision of MR Safety Advisory services and Radiation protection Adviser/Radiation Physics expert to QSE	SLA held by UCLH NHS Foundation Trust
UCLH Medical Physics and Biomedical Engineering	Provision of expert servicing, fault repair and consultancy on medical equipment used at the Queen Square Imaging Centre and Chenies Mews Imaging Centre	SLA held by UCLH NHS Foundation Trust

8.0 Core Hours of Operation

Queen Square Imaging Centre 8-11 Queen Square WC1N 3AR	**Chenies Mews Imaging Centre** 69-75 Chenies Mews WC1E 6HX
Monday 08:00 – 18:00 Tuesday 08:00 – 18:00 Wednesday 08:00 – 18:00 Thursday 08:00 – 18:00 Friday 09:00 – 17.00 Saturday* Closed Sunday Closed	Monday 09:00 – 17.00 Tuesday 09:00 – 17.00 Wednesday 09:00 – 17.00 Thursday 09:00 – 17.00 Friday 09:00 – 17.00 Saturday* Closed Sunday Closed

*Saturday lists may be arranged ad hoc for waiting list initiatives.

9.0 Workforce Planning

The Company is committed to ensuring that enough resources are available so that staff may undertake their duties safely, efficiently and in a manner, which promotes wellness and satisfaction in their work. A key part of this commitment is ensuring that the Company regularly reviews staffing levels, not only in terms of the number of staff available but also the skills mix present at any one time.

The imaging workforce is currently formed from the following funded posts:

Queen Square Imaging Centre 8-11 Queen Square WC1N 3AR	**Chenies Mews Imaging Centre** 69-75 Chenies Mews WC1E 6HX
4 x Radiographers (FT) 1 x Radiographers (0.8FTE) 1 x Radiology Department Assistant (FT) *may work cross site depending on service need. 2 x Booking coordinators (FT) 1 x receptionist (FT)	5 x Radiographers (FT) 1 x cardiology fellow post 1 x Radiology Department Administrators (FT) 2 x Radiology Department Administrators (0.6FTE and 0.4FTE)

With the support of the Operations Manager, it is the responsibility of the Superintendent Radiographers and Administration Managers to ensure that resources are utilised effectively to ensure that staffing levels are appropriate and meet the requirements of the services being provided. Patient

and staff safety remain paramount and under no circumstances should services be provided with insufficient workforce present.

All planned staff absences should be requested, approved, and recorded using the Company's Human Resources Management (HRM) system (BrightHR). Authorised absences must then be factored into staff rosters to ensure that adequate staff numbers and the appropriate skill mix is available.

Radiographer and Administration duties should be recorded and rostered at least 1 month in advance at both clinical sites, using the approved rota template. Completed rosters should be on display and accessible to all staff.

The following principles for workforce planning and appointment diary management should always be employed:

- There should be a minimum of two staff members present at any time that patients and visitors are scheduled to attend the department.

  In reference to the QSE **Health and Safety Policy** and **Lone Working Policy**, under no circumstances should any imaging investigations take place without a minimum of two members of staff in the facility. At least one member of staff must have current Immediate Life Support training, and the second staff member must be up to date with Basic Life Support training as a minimum (this may be one radiographer and one administrator). Both members of staff should be compliant with all mandatory training (unless otherwise agreed with the operations manager).

- At Chenies Mews, a total of three members of staff must be present if both magnets are in operation for non-contrast examinations.

- In accordance with the Company's Medicines Management Policies (QSIC and CMIC) and Patient Group Directives (where applicable), no imaging investigations should take place that require an injection of contrast media or any other medicines without at least two radiographers on duty on the specific magnet and two other staff members present. A doctor must also be aware of the injection and available to assist if required (although they may not necessarily be in the immediate vicinity). Rostering should always consider agreed and published emergency response algorithms (contained within the QSIC and CMIC MRI Local Safety Rules) and their requirements for staff headcount.

9.1 Managing workload in cases of unexpected staff absence.

There will be occasions of unexpected staff absence, such as in the case of staff sickness or travel disruption. Staff should be aware of and act in accordance with the policy and procedure for reporting absence through sickness, which may also translate to other unplanned absences. This procedure may be used to mitigate at least some of disruption caused by unplanned absence. As a rule, the workforce strategy for service delivery as described in section 9.0 should be adhered to

without exception. Whilst disruption and inconvenience to patients must be limited as far as possible, patient safety must always take precedence.

If the unplanned absence has resulted in insufficient head count, or insufficient skills mix to comply with the workforce strategy, the superintendent should:

1. Make an immediate assessment of the scanning list and the requirements for staff levels and skills mix (in reference to the strategy outlined above). If it is likely that patients already present will be delayed, they should be informed immediately of the situation and provided with an apology and full explanation of the situation. They should be given the opportunity to rebook if they wish.

2. If there are insufficient numbers of staff to operate safely, those staff present should liaise with the other clinical site to request additional support from staff members with the appropriate skills to maintain the required skill mix and headcount. Clinical sites should work together to identify a solution wherever possible, even if the solution is only temporary.

3. If no additional staff can be sourced and it is not safe to proceed to deliver the service with the staff members present, patients should be contacted, informed of the situation and provided with assistance to reschedule their appointment if necessary. Staff should remember that even though surplus staff may not be available from the other clinical site, it may still be possible for the patient to be scanned at that site. It may also be possible to rearrange the scanning list if the skill mix is enough for another patient to be scanned first (in the case of a non-contrast scan for example). In this scenario, the delayed patient must be kept fully informed and should only be kept waiting if there is a reasonable level of confidence that the staffing issue can be resolved in a timely manner.

4. If patients need to be rebooked, all efforts should be made to rebook the patient with a convenient appointment time of their choosing. Patients already present or on their way to the department should be helped by sourcing a scan appointment at the other clinical site wherever possible. As a last resort and only if the patient specifically requests it, staff should assist in finding an alternative appointment at another facility.

10.0 Information Governance

10.1 Patient Data

All staff should be aware of the location and content held within the Company Information

Governance Policy and GDPR Policies. The Operations Manager holds delegated responsibility for Information Governance and adherence to General Data Protection Regulations (GDPR).

Specific responsibilities of the radiology team are:

- To ensure that all relevant patient information pertaining to the imaging investigation is recorded electronically on the Radiology Information System (EPIC) and where appropriate, on the QSE Patient Booking System. No other records should be kept, and no paper records should be retained after the administration and finance functions have been completed.
- To ensure that all radiographic examinations are archived appropriately on QSE's primary archive (GE Archive) and where appropriate, the UCLH Trust PACS (CareStream).
- To issue copies of radiographic imaging and clinical reports in a timely manner to the appropriate referrer and/or authorised external organisation in accordance with data governance policies. All electronic communications must be made securely using encryption.

10.2 Image Data

The radiographer responsible for each imaging investigation (the radiographer who has performed the examination) is responsible for ensuring that images are appropriately transferred and archived to the GE Archive and PACS system. Where more than one radiographer is involved in a patient's care, the radiographer who has performed the scan is recorded as the primary radiographer on the patient's electronic health record.

Wherever possible, all imaging should be acquired using a UCLH Trust Hospital ID (produced from EPIC) as the primary patient identifier. RIS accession numbers should also be attached to images prior to archiving. In cases where this is not possible, or where a patient should not be registered on the UCLH RIS system for reasons of confidentiality, it is the primary radiographer's responsibility to ensure that images have the correct patient demographic before being archived, and that a request is made to the UCLH PACS team for unverified images on PACS to be removed.

If patients are archived without a hospital ID/accession number due to IT system downtime, records should be retained so that records can be updated as soon as the IT system is operational again. Patients should not be inconvenienced by any IT downtime.

10.2.1 Transferring and Archiving Diagnostic Images

Imaging that has been produced using a UCLH Trust Hospital ID/MRN number should be available to referrers from within the UCLH group of hospitals via Carestream PACS and the relevant web viewers. Hard copies will be produced for all private patient examinations which should be given to the patient unless a directive has been made by a referrer for the CD hard copy to be delivered to them instead. If this is the case, the CD should be sent in a sealed envelope via the internal postal system, or by secure courier.

Occasionally, images will need to be sent to external organisations via secure electronic means. The Image Exchange Portal (IEP) should be used for this purpose to ensure data protection compliance. Under no circumstances should any imaging data be transferred via Dropbox or any other unsecure platform.

QSE' Diagnostic images may also be archived to Biotronics3D, Purview and Cimar (as required) for referrers to access and report images remotely. Patients will also be given an option of accessing their images through a secure Health Portal via 3DBiotronics. This supports patient access to their imaging records in accordance with applicable data protection legislation and Company information governance procedures.

10.3 Cybersecurity

QSE recognises that digital systems, including RIS, PACS, image archives, electronic health records, booking systems and secure communication platforms, are critical to safe service delivery. Cybersecurity risks, system downtime, access control issues and data integrity concerns must be escalated in accordance with the Information Governance Policy, Business Continuity Plan and relevant IT support arrangements. Staff must not use unapproved systems or personal devices for storing, transferring or communicating patient-identifiable information.

11.0 Radiology Reporting and Communication of Results

The **Imaging Reporting Policy** provides full details on QSE's reporting standards, including turnaround time targets, report format and mode of communication. The Imaging Reporting policy also provides guidance regarding the management of unexpected diagnoses and communication of urgent reports.

Reporting of diagnostic examinations should always be performed by recognised consultants who have been entered onto the QSE Practising Privileges Register. Authorised Consultants must record their report on the RIS system (EPIC) wherever possible. For referrers from within the UCLH group of hospitals, this ensures that results are available to the referring clinician without delay. Reports will be transposed to QSE's health records system so that a hard copy of the report is also issued by the imaging facility.

Where it is not possible for an examination to be reported directly onto EPIC, reports should be entered directly onto QSE's health records system. Administrators with the necessary permissions should transpose the received report onto the relevant EPIC attendance where applicable.

Electronic transmission of results should be conducted ONLY via secure means, in accordance with the Company's information governance policies. The preferred route is via nhs.net email accounts. However, if this cannot be achieved, the Company's Egress email encryption should be used.

The communication of radiology reports in a timely manner is a key performance indicator for QSE and report turnaround times are monitored as part of the Company's programme of audit.

12.0 Receiving Images and Reports from External Organisations

It is commonplace for imaging to be provided by the patient or an external third party to our radiology departments for the purposes of comparison with examinations performed at QSE's imaging departments. Imaging may be transferred to us via IEP to the UCLH PACS, or by hardcopy.

Where external imaging is provided by CD, images should be uploaded to the QSE archive and then to the UCLH PACS. These images will retain the hospital number of the external hospital and it will not be possible for clinicians to search for external images using the UCLH hospital number until an attendance is created on EPIC for the external examination, and the imported images are linked to the new attendance by the PACS team.

The process for the upload of external images is:

- CD(s) will be received by the imaging department. If a medical secretary is providing discs for upload, they should be encouraged to also submit a completed image upload request form.
- The CD will be uploaded to the local archive via the AW or RA600 workstation. If CDs are password encrypted, this may not be possible, in which case the CD will need to be handed over to the Hospital's PACS team for action.
- The uploaded studies will then be pushed to PACS.
- A backdated ancillary order and attendance is created on EPIC for the external studies.
- The EPIC radiology team will be automatically notified so that they can merge the studies with the patient's electronic health record and sign off the order.

13.0 Patient Identification

All staff should be aware of, and work in accordance with the Company's **Patient Identification Policy**. The completion of ID checks must be recorded on the patient's MRI screening form, which should be recorded on the patient's electronic health record.

14.0 Procedures for Excluding Pregnancy

All staff must be aware of the approved procedures for establishing the likelihood of pregnancy in patients of childbearing age before they undergo a medical exposure. Staff should refer to guidance issued within the Local MRI Safety Rules, Local Rules for Radiation Safety in CT, and Employer's Procedures documents.

15.0 Patient Safety During an MRI Examination

All radiography staff must be aware of the latest version of the published **Local Safety Rules** for Magnetic Resonance Imaging for their own department. Staff who rotate between departments must be conscious of versions that relate to the department they are working in and must be certain that they are working in compliance with the local rules. **There will be differences between sites owing to the variation in scanning hardware.**

All patients, staff and visitors who are to enter the inner controlled area must only enter upon completion, and review of an MRI patient safety Screening Form. They should always be supervised by an MR supervisor. Staff who require routine access to the outer controlled area and the inner controlled area(s) must be entered into the appropriate access control list and authorised by the responsible person.

Patients with pacemakers and other medical devices must be booked and examined in accordance with the **QSE Pacemaker SOP** and the **QSE Medical Devices SOP**. It is a requirement of all staff to be familiar with these processes.

16.0 Patient Safety During a CT Examination

All radiography staff working at the Queen Square Imaging Centre must be aware of and signed to confirm they have read the latest version of the published **Local Rules of Radiation Safety in CT**, **Employer's Procedures** and **Local CT Risk Assessment**. Records of this will be maintained by the RPS.

Since the Company's CT scanner is within the MR Environment of QSIC, all patients, staff and visitors who are to enter the MR Environment must only enter upon completion, and review of the relevant safety Screening Form (even if they are not destined for the MR inner controlled area). All patients and visitors should always be supervised by an MR supervisor.

17.0 Fault Reporting

All equipment faults should be reported to the most senior radiographer onsite, although all staff are expected to be able to report faults to the relevant party for corrective action.

If equipment needs to be taken out of circulation, then a clear sign should be attached to the equipment detailing the date and nature of the fault, the person who has reported it and the job reference number.

Where a fault has affected, or may affect, patient safety, image quality, service continuity or regulatory compliance, an incident report must be completed and the issue escalated to the Superintendent Radiographer and Operations Manager.

All faults should also be recorded in the fault logbook located within the control rooms.

Contact details for reporting faults to the relevant equipment manufacturer are available in the fault logbook and within the **Premises, Facilities and Equipment Policy**.

In the case of faults with PACS or the UCLH RIS (EPIC), these should be reported to the UCH Imaging ICT Team and to the EPIC helpdesk, respectively.

18.0 Contingency Plans

The **QSE Business Continuity Plan (including Major Incident Response)** details plans to prepare QSE businesses in the event of service outages caused by factors beyond the Company's control. The intended outcome of this plan is to ensure that the business can maintain safety and a good level of service for our patients and visitors and to ensure that staff are safe.

Radiology-specific contingency arrangements must consider scanner failure, PACS/RIS downtime, power failure, loss of network access, contrast injector failure, emergency call system failure, staffing shortfall, fire, flood, security incident and loss of access to clinical areas.

18.1 Power Failure

In the event of mains power failure, all scanning modalities at the affected site(s) will become nonfunctional. Any examinations taking place at the time of the power failure should be halted and the patient removed to safety.

18.2 Equipment Failure

If there is an equipment failure during an examination, then the most senior radiographer present will decide on the most appropriate course of action. Patient safety and comfort is paramount, and patients should be removed from the magnet/CT scanner if there is any delay expected whilst trouble shooting takes place. Staff should be aware of, and act in accordance with the Premises, Facilities and Equipment Procedure document and the rehearsed contingency plans outlined in the Radiation Contingency Plans and Risk Control in CT document.

19.0 Sickness Policy

Staff should be aware of the Company's Policy for absence through sickness which can be found in the QSE Employee Handbook. Specific responsibilities for radiographers are:

- On the day of absence, the staff member should phone and speak directly with the Superintendent or Operations Manager at least 1 hour prior to the start of their shift. If the radiographer is on an early duty and should be the first person to arrive, every effort should be made to communicate their absence via group messaging.
- When calling in sick, the staff member should state the nature of their illness, how long they think they may be absent for, and if they have any specific duties which may be affected.
- Depending on the nature of the illness, staff should ring daily to provide an update, unless a medical certificate has been issued and communicated to their line manager in relation to the specific episode of absence.

20.0 Education and Training

All staff must take individual responsibility for compliance with their own mandatory and statutory training needs, as identified in the **Mandatory Training Policy and Training Needs Analysis**. If there is any reason why a staff member cannot remain compliant, this should be communicated with their line manager as a priority.

21.0 Complaints, Concerns, and Incidents

Incidents, near misses and concerns must be reported through the Company's approved incident reporting system in accordance with the Incident Reporting Policy. Incidents are reviewed to identify immediate safety actions, contributory factors, learning, themes and any required changes to practice. Where an incident meets the threshold for statutory Duty of Candour, the Company will ensure that patients or their representatives receive a timely apology, explanation and appropriate follow-up in accordance with the Duty of Candour Policy.

All formal complaints are handled in accordance with the **QSE Complaints Policy**. Updates on complaints and incidents forms an important part of the governance update at the monthly Quality and Clinical Risk Management meetings and monthly team meetings. All compliments made through the Company's patient feedback systems are communicated to staff through the performance dashboard for discussion at governance meetings. Specific comments are shared with the staff involved.

Further information may be found in the QSE **Patient Feedback Policy and SOP.**

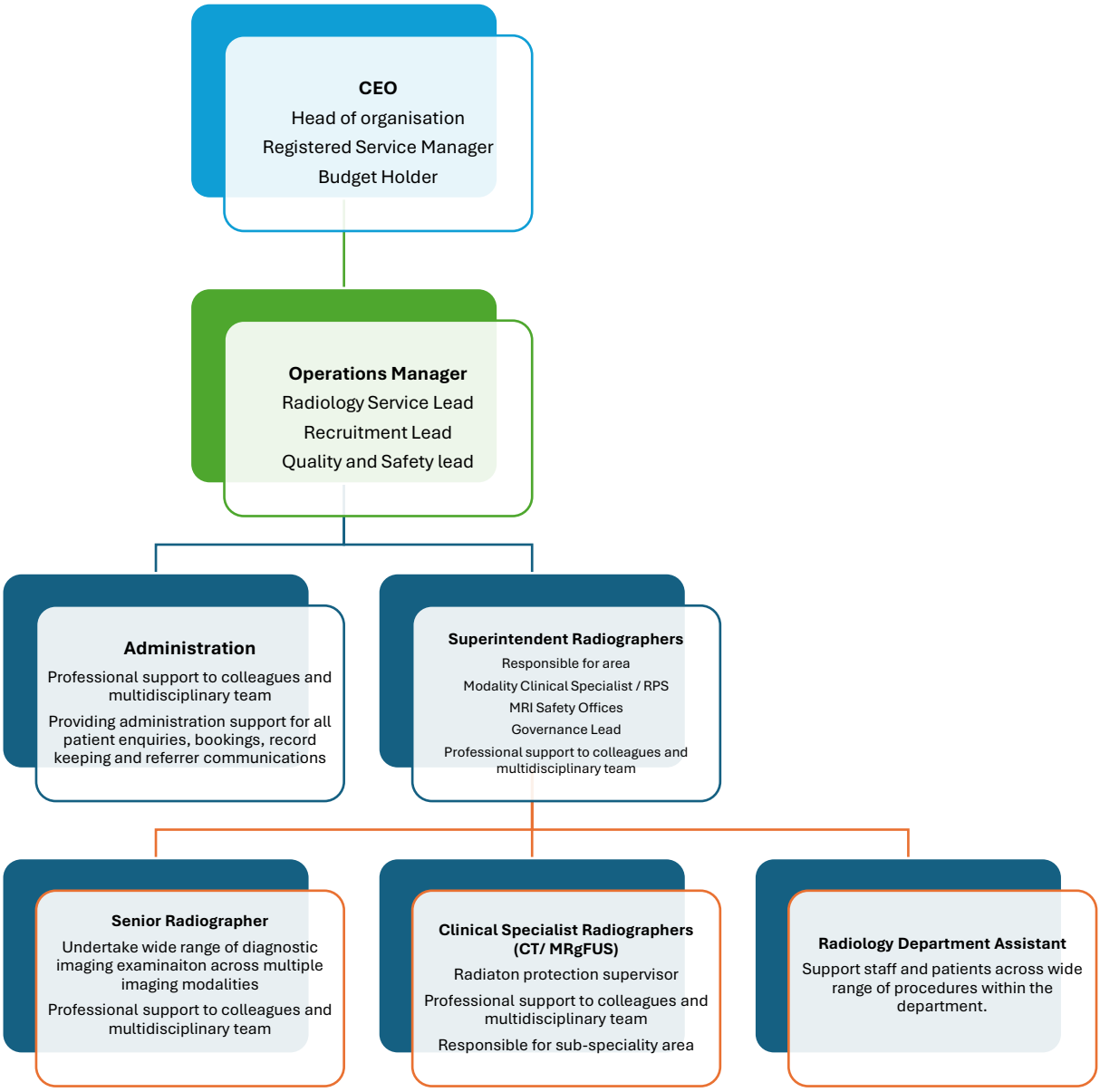
22.0 Risk Management

Risks to patient safety, staff safety, service continuity, regulatory compliance and service quality are identified through incidents, audits, complaints, staff feedback, equipment faults, changes in service

delivery, external guidance and routine operational review. Risks are recorded on the Company's risk registers and reviewed through the Quality, Safety and Clinical Risk Management Subcommittee.

High or escalating risks are reported to the senior management team and, where appropriate, to the Board. Controls and actions are reviewed for effectiveness and residual risk is monitored until the risk is closed or accepted at the appropriate level.

Appendix 1. Radiology Service Organisational Chart – Imaging Services Structure and operational lines of accountability.



Equality Impact Assessment (EIA)

This Equality Impact Assessment provides evidence for meeting the Company's commitment to equality and the responsibilities outlined above, for more information about QSE's commitment to equality, please refer to the Diversity, Equality, Inclusion and Human Rights Policy and Equal Opportunities Policy.

For each protected characteristics, answer the questions below by indicating. Yes (Y) or No (N)	Sex (male / female / transgender)	Age	Race/Ethnicity	Disability	Religion/Belief	Sexual Orientation	Marriage/Civil Partnership	Pregnancy and Maternity	Carers	Other Group	List Negative/Positive Impacts below
Does the policy have the potential to affect individuals or communities differently in a negative way?	No	No	No	No	No	No	No	No	No	No	
Is there potential for the policy. to promote equality of opportunity for all / promote good relations with different groups (a positive impact)?	Yes	No	No	Yes	No	No	No	Yes	No	No	Provisions within policy are made to reduce the use of language which may discriminate against transgender and nonbinary individuals.
For each protected characteristic, are there any areas where you are unsure about the impact and more information is needed?	No	No	No	No	No	No	No	No	No	No	

Assessor Name:	Peter Sutton	Role:	Operations Manager	Signed:	P. Sutton	Assessment date:	09/06/2026