

The Jack Brignall PET-CT Centre

Quality Report

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Website: www.alliancemedical.co.uk/scan-centres/jack-brignall-petct-centre Date of inspection visit: 1 March 2019
Date of publication: 20/05/2019

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

Ratings

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

Overall summary

The Jack Brignall PET-CT Centre is operated by Alliance Medical Limited. The centre facilities include; reception and waiting areas; an administrative area, which includes a research office, and a clinical area

includes two scanner rooms, eight uptake rooms, accessible male and female hot toilets (only to be used by patients who had their received radioactive injection) and two laboratories.

The service provides diagnostic imaging using PET-CT. A PET-CT scan is a combination of a PET (positive emissions

Summary of findings

tomography) scan and a CT (computerised tomography) scan. PET-CT scans are usually performed to help with the diagnosis, assessment and treatment of; cancer, heart and circulatory conditions and neurological (brain) abnormalities.

The centre did not scan children under 18 years due to lack of paediatric support on site

We inspected this service using our comprehensive inspection methodology. We carried out a short notice announced inspection on 1 March 2019.

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

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

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

We found good practice in relation to:

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. We found good practice in relation to medicines management, record keeping, infection prevention and control and assessing and responding to patient risk.

The department had shown overall good compliance with the Ionising Radiation Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017, however some actions were needed.

Staff were competent in their roles and worked well together to provide good patient care. Care was provided using policies and procedures based on relevant national guidance and evidence-based practice. Effectiveness of care was monitored and benchmarked against other Alliance Medical Limited providers to maintain and improve standards.

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Patients told us all staff were helpful and understanding, informative, polite, reassuring and explained things well.

The service planned and provided services in a way that met the needs of their patients. Staff ensured patients' individual needs were met. Patients could access the service when they needed it, appointments were prioritised and reports were made available to referring clinicians in a timely way.

The aim of the service was; to provide high standards of diagnostic imaging to meet the needs of referrers and their patients. The manager monitored service performance and engaged well with patients, customers, commissioners and staff to ensure they met this aim. The service had good systems in place to identify risks and plan to eliminate or reduce them and was committed to learn from when things went wrong or well. The manager of the service had the right skills and abilities to run the service providing high-quality sustainable care.

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

The service did not have a second radiation protection supervisor.

Categorisation of incidents and implementation of recommendations from incident investigations and quality assurance reviews needed to improve.

Where suggestions had come from patient surveys there needed to be some mechanism for informing patients what improvements had been made from their feedback or that their ideas had been considered but the service had not been able to progress them and why.

Patients sometimes had to have their scan rearranged due to problems escorting them from inpatient wards to the department in time for their scan.

There had been a gap of several months when there had been no staff meetings at the centre.

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

Ellen Armistead

Summary of findings

Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service

Diagnostic imaging

Rating

Good



Summary of each main service

We rated this service as good overall with ratings of good for safe, caring, responsive and well-led. CQC does not rate effective for diagnostic imaging services. There were areas of good practice and a small number of things the provider should do to improve. Details are at the end of the report.

Summary of findings

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Good



The Jack Brignall PET-CT Centre

Services we looked at

Diagnostic imaging

Summary of this inspection

Background to The Jack Brignall PET-CT Centre

The Jack Brignall PET-CT Centre is operated by Alliance Medical Limited. The centre opened in May 2014 in partnership with the Daisy Appeal Charity and Hull and East Yorkshire Hospitals NHS Trust. It is a private centre built on the site of Castle Hill Hospital (part of Hull and East Yorkshire NHS Trust) at Cottingham, in the East Riding of Yorkshire. The service primarily serves the communities of the East Yorkshire and North-East Lincolnshire areas but also accepts patient referrals from outside this area.

The centre provides its services under a NHS national contract arrangement.

The centre focuses on scanning of oncology patients, but service developments are evolving around cardiology and neurology. The service is open 5 days per week (Monday to Friday) and offers around 85 slots per week between the hours of 7.30am and 7.30pm

The centre has had a registered manager, James Reid, in post since April 2014.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and a specialist advisor with expertise in radiology. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Information about The Jack Brignall PET-CT Centre

The centre is registered to provide the following regulated activities:

- Diagnostic and screening procedures

The service provided diagnostic imaging services to NHS and self-funded patients.

The centre employed 10 staff (6.8 full time equivalent); one centre manager, four PET-CT radiographers (two of these were bank staff), and five clinical assistants. Additionally, there was one full-time receptionist provided by the host trust under a service level agreement.

Radiologists provided medical support and reporting of images under a service level agreement with the host trust but were not directly employed by the service.

During the inspection, we visited all areas of the centre. We spoke with six members of staff including the manager, a radiologist, radiographers and a clinical

assistant. We followed a patient pathway and spoke to the patient and their interpreter. We reviewed information about the service including patient feedback about their experience.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. This was the clinic's first inspection since registration with CQC.

Activity (October 2017 to September 2018)

In the reporting period October 2017 to September 2018, 3,071 patients attended the Jack Brignall PET-CT Centre; 3,065 were NHS funded and six patients were self-funded.

Track record on safety:

- Zero Never events
- Zero Serious injuries
- Clinical incidents 39: 11 low or no harm, seven moderate harm, four near misses and 17 unknown harm

Summary of this inspection

- Zero incidences of hospital acquired Methicillin-resistant staphylococcus aureus (MRSA),
- Zero incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- Zero incidences of hospital acquired Clostridium difficile (C.diff)
- Zero incidences of hospital acquired E-Coli
- Zero complaints

Services accredited by a national body:

Alliance Medical Limited was accredited with;

- The Imaging Services Accreditation Scheme (ISAS) from July 2018 to June 2021

- ISO 27001, the international information security standard from June 2018 to June 2021
- Investors in People until March 2020

Services provided for the clinic under service level agreement:

The Radiation Protection Adviser, radioactive waste management, medical physics expertise, medical emergency response, reception cover and cleaning services were all provided under a service level agreement with the host trust.

Specialist pharmacy support was available to the centre through Alliance Medical Limited.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. At March 2019 compliance with mandatory training was 100% for all modules
- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean.
- The service had suitable premises and equipment and looked after them well.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary
- 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.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service followed safe practice when giving, recording and storing medicines.

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

- The service needed to train a second radiation protection supervisor to ensure cover when the registered manager was absent
- Categorisation of incidents and follow up of recommendations from incident investigations needed to improve

Good



Are services effective?

We do not currently rate effective for diagnostic imaging services.

We found the following areas of positive practice:

- The service provided care based on national guidance and evidence of its effectiveness. Radiation protection advisers and supervisors checked to make sure staff followed guidance.
- Staff assessed and monitored patients regularly during their scan to see if they were uncomfortable or in pain.

Summary of this inspection

- The service made sure staff were competent for their roles. Managers appraised staff's work performance, provided support and monitored the effectiveness of the service. They compared local results with those of other services in the Alliance Medical Limited group to learn from them.
- Staff of different kinds worked together as a team to benefit patients. Staff supported each other to provide good care.
- Staff understood their roles and responsibilities under the Mental Capacity Act 2005 and in relation to informed consent.

Are services caring?

We rated caring as **Good** because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Patients told us all staff from the receptionist to the scan operator were all very comforting, pleasant and competent. Staff were helpful and understanding, informative, polite, reassuring and explained things well.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care.

Good



Are services responsive?

We rated responsive as **Good** because:

- The service planned and provided services in a way that met the needs of local people.
- The service took account of patients' individual needs.
- Staff were understanding of individual needs and made every effort to make sure the service was accessible to all their patients.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

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

- Patients sometimes had to have their scan rearranged due to problems escorting them from inpatient wards to the department in time for their scan.

Good



Summary of this inspection

Are services well-led?

Good



We rated well-led as **Good** because:

- The manager of the service had the right skills and abilities to run a service providing high-quality sustainable care.
- The aim of the service was to provide high standards of diagnostic imaging to meet the needs of referrers and their patients.
- The service systematically checked service quality and safeguarded high standards of care.
- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service promoted a positive culture that supported and valued staff.
- The service engaged well with patients, staff, the trust and commissioners to plan and manage appropriate services.
- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation

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

- There had been a gap of several months when there had been no staff meetings at the centre.
- The risk relating to staff exposure did not include the new recommendations from a recent incident investigation.
- There was no process in place to inform patients what improvements had been made because of their feedback or to inform them when suggestions had been made but were not feasible for implementation.

Diagnostic imaging

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Good 

Are diagnostic imaging services safe?

Good 

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Staff received several mandatory training modules, which included; complaints handling, conflict resolution, fire safety, equality and diversity, infection prevention and control, safeguarding children and adults, information governance, moving and handling, Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) and immediate life support training.
- At March 2019 compliance with mandatory training was 100% for radiographers and clinical assistants for all modules.
- Training was a mixture of online and face to face, staff told us they were up to date with their training.
- The service kept details of training requirements for employees and staff were alerted when retraining / refreshers were needed.
- There was a comprehensive induction plan for new starters which included local requirements such as knowledge of the local rules document, fire evacuation plan, local staff facilities and access codes to relevant areas, introduction to local staff from both the Nuclear Medicine Department and the PET-CT Centre.

- Medical Devices Assessments were completed by all clinical staff for: the scanner, the dose calibrator (relevant to role)

Safeguarding

- **Staff understood how to protect patients from abuse.** Staff had training on how to recognise and report abuse and they knew how to apply it.
- There were safeguarding policies in place for children and adults, which outlined staff responsibilities with regards discussion with senior staff and reporting to the local authority and or police as appropriate.
- Staff had access to local procedures which included who to contact for support, information and telephone numbers to contact the relevant local authorities or police departments.
- Staff had access to a safeguarding lead trained to level four, within the wider Alliance Medical Limited group.
- All staff had received level one and level two training in children's safeguarding, this met intercollegiate guidance: Safeguarding Children and Young People: Roles and competencies for Health Care Staff (March 2014). Guidance states all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers should be trained to level two.
- All staff had received adult safeguarding training at level one and 30% of staff had received adult safeguarding training at level two. Although this was in line with requirements, level 2 adult safeguarding training would be best practice for any clinical staff.
- The centre did not scan children under 18 years due to lack of paediatric support on site.

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- At the time of inspection, all employed staff had been checked through the Disclosure and Barring Service as part of the recruitment process. The manager told us that there had been a recent change to policy which meant staff would be re-checked every three years instead of every five years, although this had not yet been completed for all staff. Two staff were still to be re-checked at the time of inspection as they had last been checked in 2014.
- The staff we spoke with showed an understanding of their responsibilities regarding safeguarding and were aware of who they needed to contact within the service and the local authority if they had a safeguarding concern.
- We saw staff cleaning their hands between patient contacts and hand gel was available for patients in the reception / waiting area.
- There was an appointed radiation waste advisor as part of a service level agreement with the trust to provide waste management services.
- We found that infection prevention and control was audited as part of the annual Alliance quality assurance review and an annual report was produced. In October 2018 the centre achieved an overall score of 98% which was consistent with the earlier year's audit. This score was better than the company benchmark of 90% compliance.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well.** Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The centre manager was the lead for infection, prevention and control. All staff had received training in infection, prevention and control including hand hygiene.
- There were policies and procedures in place which provided staff with guidance on appropriate practice for example, cleaning schedules, hand hygiene and decontamination of equipment before servicing or repair. The policy also covered management of infectious patients.
- There were hand washing facilities and gels, cleaning solutions, spill packs and personal protective equipment were available if needed.
- The department was visibly clean and tidy and there were cleaning schedules for the different areas of the clinic. Patient feedback was that the unit was clean.
- Daily cleaning of the centre was under a third-party agreement with the host trust, the unit manager told us they checked performance and gave feedback on required actions. Staff undertook cleaning of clinical equipment and there were schedules and cleaning records to show that schedules were completed appropriately.
- Hand hygiene audits were carried out monthly; in October 2018 it was reported that the hand hygiene audit had been completed for all clinical staff every month during the previous 12 months, with the mean score being 98%. There was an area of development noted with minor issues relating to bare below elbows which the unit manager addressed with staff.
- The monthly insertion of peripheral vascular device audits for the same 12-month period showed a mean score of 100% with no areas of concern noted.
- We saw a patient being cannulated for administration of the radioactive tracer. We saw staff performing cannulation used good aseptic technique and washed their hands correctly before and after the procedure.
- Patients' cannulas were removed in the treatment room and disposed of correctly as clinical waste.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
- The centre was purpose-built, it was a clean, light and airy environment split into three main areas: reception and waiting areas; administrative area and a clinical area.
- The clinical area was further split into controlled and supervised areas which were clearly identified by warning signs and locked doors. All clinical and administration areas were secure with electronic locks needing swipe card access.

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- The centre had cold and hot waiting areas for patients before and after they had received their radioactive tracer injection.
- There were individual uptake rooms for patients where they could change in private, where they received their injections and waited for their scan.
- Staff could see patients from the control room during the scanning process.
- During scanning the patients were monitored from the control room via CCTV and staff communicated with patients via intercom throughout the scan.
- There was a hand-held alarm button in the scanner that patients could press if they wanted to stop the scan for any reason.
- There was an equipment maintenance agreement in place that covered, planned and essential maintenance, repairs and quality assurance.
- There were maintenance records that showed when equipment had last been serviced and when the next service was due. All equipment checks were in date.
- Staff told us that repairs were usually made quickly, and engineers could access the scanner remotely to fix some faults. However, as there one scanner, and due to the rapid degeneration of the radioactive tracer injection, unexpected faults could lead to patient delays and appointments needing to be re-booked.
- All the equipment we viewed conformed to relevant safety standards and was serviced on a regular basis. We saw that electrical equipment was safety tested.
- Staff carried out daily quality assurance checks on the scanner to ensure it performed safely and to specification. We saw records which provided evidence that daily quality assurance checks, on the equipment were carried out.
- Staff had been trained in the safe and effective use of the scanner and were assessed as being competent before being allowed to carry out scans unsupervised.
- We checked the unit's resuscitation trolley during the inspection. There was a process in place to check the contents and expiry dates of the equipment and emergency medicines. Records indicated this was done daily and after use.
- Emergency call bells were available in the patient uptake rooms and toilets.
- Patients told us the centre was clean, calm and comfortable.
- There was parking available near the centre with disabled parking just outside.
- There were fire safety signs and a fire extinguisher was accessible, fire safety checks were made weekly.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient.** They kept clear records and asked for support when necessary
- The centre manager was the radiation protection supervisor for the service and one of the supporting consultants was the nominated radiation protection adviser.
- The most recent Radiology Protection Advisor's audits of compliance with Ionising Radiation Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017, in March 2018 and May 2018 respectively, found that: Overall, the department showed good compliance with the regulations. Most written procedures and protocols were in place; duty holders were identified; and audits/risk management were carried out. Working practices mirrored procedures and a positive culture was apparent.
- Safety manuals for operators and Local Rules were easily accessible within the scan room and were in date.
- The Radiology Protection Advisor's reports also made several recommendations for improvements. We saw that the majority of required actions had been completed and progress had been made against the others. One of the recommendations not yet completed was that was that the centre needed to have a second trained radiation protection supervisor. The manager had identified a member of staff who was willing to undertake the role and was currently looking for a training provider
- From October 2017 to September 2018 there was one urgent transfer from the department to the acute

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hospital emergency department. The transfer was due to a patient becoming unwell in the department and was not related to any investigation or treatment carried out.

- All staff were trained in immediate life support and staff were aware how to raise an alarm if a patient became seriously unwell or collapsed. The trust provided an emergency response team to the centre as part of a service level agreement.
- Staff told us about a patient who had collapsed in the department, they told us the emergency response in the department and from the hospital was quick, well managed and was in line with patient wishes.
- The clinic kept an electronic list of approved referrers. Staff told us if a referral was received from a new referrer they would check on the General Medical Council (GMC) website to check their registration status. The centre only accepted referrals from doctors.
- Referrals were initially received by the trust nuclear medicine admin team and quality checked to ensure all required information was available. A consultant radiologist then vetted and triaged the referrals to establish urgency and priority for appointment booking.
- If the radiologist felt the referral was inappropriate or they needed further information they would contact the referrer. The radiologist was accountable for ensuring referrals were appropriate, determining if there were any contraindications and deciding if the scan should go ahead.
- The booking team contacted the patient via telephone to explain the procedure and complete a safety questionnaire.
- A 'PET-CT Patient Data Form' form was given to patients to fill in before attending the clinic, on arrival staff confirmed this information with the patient and checked that there were no reasons why the scan should not go ahead. Checks included determining whether a patient could be pregnant. The patients completed this form themselves as a self-declaration which doubled as a consent form.
- The radiographer went through the patient data form to confirm the information the patient had provided. If

the radiographer had any concerns about information the patient provided which may contraindicate a scan staff told us they would speak to one of the consultant radiologists before continuing.

- We saw that staff followed a patient identification policy and ensured that patients were correctly identified and that referral information and body part to be examined were verified, with the patient. Staff used a 'Pause and check' before entering the scan room. The 'Pause and check' is a clinical imaging examination operator checklist
- There were alarm call bells in the toilets, uptake rooms and controlled areas.
- All staff wore personal dosimeters to record radiation exposure levels. Whole body and finger doses were recorded and checked. The unit's radiation protection supervisor monthly reviewed levels.
- We saw that there were defined acceptable radiation levels for whole body and for fingers and that when these doses were high they were investigated by observing staff practice and technique and corrective action was taken where necessary.
- Inpatients attending the unit came with a nurse escort from the ward to ensure continuity of care and meet patient needs when they were in the uptake room receiving their injection and waiting for their scan. The escorts were given a radiation protection induction/ briefing on the day.
- Central Alerting System emails and equipment safety notices from manufacturers were received by the manager who shared them with the team, when relevant.
- There was a process in place in case the findings of an examination needed urgent referral to a medical practitioner, this included if the radiographer detected an unexpected finding during a scan or if an unexpected finding was detected by a radiologist at reporting stage.

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.**

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- The unit was staffed in line with the Alliance Medical Limited policy which stated that at least two members of staff on duty must be trained in the recognition and management of the deteriorating patient and that a clinical member of staff trained in immediate life support must always be on site during service delivery. We found that the minimum staffing for the centre was two trained radiographers and one clinical assistant and the usual staffing was two or three radiographers and two or three clinical assistants depending on the expected activity.
- The centre employed 10 staff (6.8 full time equivalent); one centre manager, four PET-CT radiographers, (two of these were bank staff) and five clinical assistants. Additionally, there was one full-time receptionist provided by the trust under a service level agreement.
- Three members of staff had joined the service in the last 12 months (two radiographers and one clinical assistant) and two had left (one radiographer and one clinical assistant).
- There was a vacancy for one full-time radiographer and the centre manager had asked for an additional full-time clinical assistant to be funded.
- The service did not use agency staff in the three months before the inspection. The centre had its own bank staff who covered 26 radiographer shifts and 40 clinical assistant shifts in the three months before the inspection.
- Average sickness rates were 0% for radiographers and 7% for clinical assistants. The unit manager had an extended period of absence during the last 12 months.
- There was a rota in place for consultant radiologist reporting of scans and radiologist support was available in the department or via the telephone at all times.
- The reception area was staffed by a trust receptionist between 7.45am and 3.45pm, and by a clinical assistant until 7.30pm.
- All patient and clinical information was recorded on an electronic radiology information system. As the system was not integrated with the NHS England data management system this meant that an image exchange portal and a direct virtual private network (VPN) were used to share the relevant data such as report and images relating to the PET-CT Scan.
- Any sharing of information with commissioners was by secure email.
- The Alliance Medical Limited 'Image Transfer and Case Management Team' managed IT processes and security centrally.
- Details of the scan protocols used, scan area and positioning were recorded on the patient data form and staff signed the form when they had input the information into the radiology information system.
- The paper copies of the contraindication form, the patient data form and the patient agreement form were scanned onto the radiology information system then shredded.
- Patients were given a form which told them how their data could be used, and they were asked to sign a patient agreement form for data use.
- Records were kept in line with the principles of the Data Protection Act 1988 and the clinic had a records management policy that covered security, storage, documentation and retention / destruction.

Medicines

- **The service followed best practice when giving, recording and storing medicines.**
- The service followed safe practice when giving, recording and storing medicines.
- The centre and the radiologists all held current licences with the Administration of Radioactive Substances Advisory Committee which meant they were legally able to use nuclear medicines.
- A radioactive tracer, FDG (fluorodeoxyglucose) was given to patients intravenously as a tracer for the CT-PET scan. Because cancer grows at a faster rate than healthy tissue, cancer cells absorb more of the FDG which enables the scan to differentiate tumours from normal tissue.

Records

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

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- FDG injection details including type of cannula used, whether extravasation occurred and any normal saline used for flushing were recorded on the PET-CT Patient Data Form and the information was input to the radiology information system at the end of the procedure.
- If a patient needed to take any other medicines while they were in the department this was also recorded on this form and a record was made that the cannula had been removed before the patient left the centre.
- As FDG degenerates quite quickly, stocks were ordered on a named patient basis, were delivered daily and staff ensured that scans occurred on time.
- The radio-active tracer was administered by trained radiographers using patient specific directions. A patient specific direction is a written instruction, from a qualified and registered prescriber for a medicine including the dose, route and frequency, or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis.
- The patient specific directions were checked by two radiographers with the radio-active tracer to ensure this was the correct dose and in date before being administered. The administration details, including batch number, were recorded on the patient's 'PET-CT Patient Data Form' which was signed by the radiographer who administered the tracer. These details were also entered onto the radiology information system record.
- If a patient was late for an appointment the staff considered the life expectancy of the FDG and whether there would be an impact on other patients if a scan started late. Staff told us these considerations sometimes meant that patients who were late needed to have their appointment rearranged.
- Emergency medicines were stored securely and monthly checks were made to ensure these were within expiry dates.
- Contrast medium was used rarely and was obtained from the trust on an individual patient basis when needed. The centre had secure storage and warming equipment for contrast medium.

- Patients were advised in the information leaflet to take their own medicines as usual on the day of their scan.

Incidents

- **The service was inconsistent in its categorisation of incidents and the estimation of harm.** Despite this, staff recognised incidents and reported them when they occurred. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff told us they could report incidents and were encouraged to do so and any relevant incidents would be reported to the Health and Safety Executive in line with regulatory requirements. Staff told us radiation incidents would be reported to the CQC as appropriate under Ionising Radiation (Medical Exposure) Regulations.
- The categorisation of incidents was not consistent regarding degree of harm, for example staff exposure was sometimes recorded as moderate harm and sometimes as unknown. There were a large proportion of incidents recorded as unknown harm, these included patient scan delays due to equipment failure.
- From October 2017 to October 2018 the centre reported 39 incidents. Seventeen of these were recorded as harm unknown, 11 were low or no harm, seven were recorded as moderate harm and four were recorded as near misses. Nine incidents were related to staff exposure and there were six incidents of extravasation all recorded as no harm.
- Most of the staff exposure incidents were where staff finger doses were raised, technique had been observed and altered as a result. Subsequently monthly doses had improved to within acceptable levels. However, for one member of staff the recommended annual dose had been exceeded and there was no identified plan for that member of staff to restrict practice or duties to lower the cumulative dose.
- We saw from the unit's quality assurance review October 2018 that an auto dispenser could be

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requested to reduce the exposure to the radioactive tracer injection from drawing up. Although some progress had been made against this action this was still open and in early stages of investigation.

- There was an incident reporting and investigation policy in place which included duty of candour policy. The duty of candour is a statutory (legal) duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future.
- Staff could articulate what duty of candour meant and understood the principles of being open with patients when something went wrong. They told us they would let a patient know at once if anything went wrong.
- Learning from incidents was shared across the Alliance Medical Limited group via a monthly risk bulletin and we saw that incidents were discussed with staff at their meetings. However, there had been a gap of several months when meetings had not been held.
- During the inspection we saw that a patient arrived from a ward late and the scan was not able to go ahead. Staff told us this happened occasionally but they did not usually report this as an incident. They did feel that something needed to be done about this to prevent patients' scans being delayed. Following our discussion staff said they would report this as an incident and they would report this type of incident in the future.

Are diagnostic imaging services effective?

We do not rate the effectiveness of diagnostic imaging services; however, we found the following during our inspection.

Evidence-based care and treatment

- **The service provided care based on national guidance and evidence of its effectiveness. Radiation protection advisers and supervisors checked to make sure staff followed guidance.**

- The provider had developed local rules for PET-CT scanning, these were very comprehensive and in line with practice guidance.
- The local rules were based on the relevant Medicines and Healthcare products Regulatory Agency guidelines.
- There were also several protocols for routine scan sequences and referral specific scans which were readily available in the scan room. The protocols were developed by the trust radiologists and staff did not vary these without discussion with a radiologist
- We reviewed several policies and procedures were based on current national guidance and best practice. All policies were in date and there was as policy version control process in place. PE-CT guidance was based on Royal College of Radiology guidelines.

Nutrition and hydration

- Patients could access water while waiting for their scan and were given a hot or cold drink and a biscuit following their scan.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were uncomfortable or in pain.**
- Staff demonstrated they were aware that patients may be in pain and they ensured the scan caused as little discomfort as possible. Positioning aids were available if needed and staff checked on patients' comfort via the intercom during the scan sequences.
- Staff gave an indication of the time the scan would take and checked that patients would be able to remain comfortable and still during the examination. Patients could alert staff if they were uncomfortable and needed the scan to stop.

Patient outcomes

- **Managers monitored the effectiveness of care and used the findings to improve them.** They compared local results with those of other services in the Alliance Medical Limited group to learn from them.
- The service did not provide a treatment to patients which enabled them to measure patient outcomes.

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However, the service did complete audits and quality assurance tests to ensure that they provided a service to measurable standards which they could monitor with the aim of making improvements.

- The service collected patient feedback, audited waiting time from first contact to scan, turnaround times for reports and image and reporting quality audits.
- From October 2017 to September 2018 around 82% of scans were reported on within five working days, 96.5% were reported within seven working days. The target for five-day reporting was 75% and the seven-day reporting target was 100%. The five-day turnaround time performance was in the lower quartile when benchmarked against the rest of the Alliance Medical Limited group. The seven-day target performance benchmarked in the second quartile when compared with the rest of the group.
- There was a quality assurance mechanism in place which included the audit of image quality. Results the audit of 339 images from October 2017 to September 2018 showed that 98.53% of images from this centre had an image quality score of five (this was on a scale of one to five with one meaning the images were uninterpretable and five meaning the images were perfect / had no artefacts.) None of the images were graded as one or two, one was graded as three (one or more sequences may have artefacts - with considerable impact on the diagnostic value of the images) and four were graded as four (minor artefact – no impact on diagnostic value). These results were better than the cumulative Alliance Medical Limited data which showed 92.1% achieving a score of five.
- The service audited image reports, looking at diagnosis and language. Any discrepancies were highlighted and fed back to the reporter for personal reflection. Any significant discrepancies were discussed between the auditor and the reporting radiologist. Report accuracy was graded as one to five; with five as complete agreement and one as serious interpretive or reporting discrepancy. Results for the Jack Brignall Centre could not be disaggregated from the other Alliance PET-CT locations, but overall results showed 64% of scans were graded as five, 26% were graded as four – (trivial disagreement 'sense

discrepancy or word omission'), 9% graded as three minor interpretive or reporting discrepancy, less than 1% as grade two (Moderate interpretive or reporting discrepancy) and none were graded as a one.

- We heard patients being given verbal instructions before leaving the clinic to let them know when their scans would be reported and when they could expect them to be back with the referring clinician.
- The service took part in the Imaging Services Accreditation Scheme (ISAS) and was accredited from July 2018 to Jun 2021

Competent staff

- **The service made sure staff were competent for their roles.** Managers appraised staff's work performance, provided support and monitored the effectiveness of the service
- Staff had received training relevant to their role. We saw training records that showed the required training and level of competence of different members of staff. Each staff member's role and operator level were recorded.
- Scanning was always undertaken by a qualified radiographer with expertise in PET-CT scanning. Bank radiographers were given an induction and training regarding the unit, policies and procedures and safe use of the scanner. Staff underwent competency assessments before being allowed to perform a scan unsupervised.
- The radiographers and clinical assistants were all trained and assessed as competent in; PET-CT safety and use of equipment. Radiographers were trained and assessed as competent to cannulate, administer intravenous radioactive tracer and medicines and to identify and manage adverse reactions.
- All staff were assessed as competent to do their work and received annual appraisals. Staff had individual timed objectives and progress / achievement of these was reviewed mid-year.
- Data provided by the centre showed that 100% of staff employed for more than 12 months had received an annual appraisal in the last 12 months.
- The service manager had checked the professional registration status of their radiographers and all were

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appropriately registered until 2020. They told us they routinely checked registration status on recruitment and that the corporate Alliance Medical Limited human resource team made annual checks.

- Reception and cleaning staff were included in PET-CT / Radiology safety training which meant they had the relevant safety knowledge and understanding to enter the controlled areas if needed.
- Staff told us that training and development was supported, this ensured competence was maintained and registered professionals met re-validation / re-registration requirements.

Multidisciplinary working

- **Staff of different kinds worked together as a team to benefit patients.** Staff supported each other to provide good care.
- We saw that the team included, the centre manager, radiographers, clinical assistants, radiologists and administration staff who all worked well together to provide a cohesive service to their patients. Staff had a good understanding of each other's roles and valued each other's contribution to the team.
- Members of the team communicated well with each other and gave examples of when they had liaised with radiologists for advice and support.
- Staff told us that the reporter or agreed delegate presented the scan and written report for discussion at the local multi-disciplinary team meetings.
- Referring clinicians could contact reporting clinicians to discuss results if needed.
- Staff described good working relationships with the trust hospital staff and gave examples of when the services had worked together to ensure patients had the best service possible.

Seven-day services

- The centre was open from 8am until 8pm Monday to Friday and occasionally held an extra session on a Saturday as required to meet demand for the service.

Consent and Mental Capacity Act

- **Staff understood their roles and responsibilities under the Mental Capacity Act 2005.**

- Staff had received training regarding Mental Capacity and consent as part of their safeguarding adults training. Staff we spoke with understood mental capacity and informed consent and patients were given enough information to consent to the PET-CT scan.
- There was a process in place which combined patient consent with other recorded information. This ensured patients were informed of the risks of PET-CT and were checked to ensure there were no contraindications for the scan going ahead.
- A 'PET-CT Patient Data Form' form was given to patients to complete as a self-declaration of medical history and which doubled as a consent form.
- Staff told us they would not go ahead with a scan if a patient refused or was unable to consent.
- There were policies in place regarding consent and mental capacity.
- Where chaperones or interpreters were to stay with patients throughout the procedure, they were informed of risks and asked to complete a disclaimer.

Are diagnostic imaging services caring?

Good 

Compassionate care

- **Staff cared for patients with compassion.** Feedback from patients confirmed that staff treated them well and with kindness.
- We observed that all staff were polite and courteous to patients from arriving at the department to when they left.
- Patients were shown to individual uptake rooms to maintain privacy and dignity. They could change and rest here in privacy while waiting for their scan. Staff ensured patients' personal belongings were placed in individual lockers when the patient went into the scan room.
- Staff escorted patients from one area to another and treated patients with dignity and respect.

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- We saw staff confirmed with patients that they could hear the radiographer before starting the scan.
- We observed staff communicating with patients through the intercom to ensure patients were as comfortable as possible during the procedure.
- The patient we spoke with told us they were happy with the service and that they had been talked through what to expect at every stage of the process.
- Patients were offered the opportunity to give feedback after their scan. Managers collated the information from patient feedback and shared the findings with staff so improvements could be made.
- Patient feedback from surveys was very positive about the service and staff. Staff were described as friendly, caring and supportive and the service was described as quick, professional, easy to access and efficient.
- Patients said that all staff from the receptionist to the scan operator were all very comforting, pleasant and competent. Staff were helpful and understanding, informative, polite, reassuring and explained things well.
- Patients could have a relative stay with them or a chaperone on request. Chaperones needed to give informed consent if they were to stay with a patient throughout the procedure.
- Staff told us they felt they provided a good service and would be happy for their friends or relatives to receive care at the centre.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- Staff told us how they supported patients within the scan room for example when patients may be nervous about the scan procedure or anxious due to the confined space of the scanner itself.
- Staff told us they would stay in the room with the patient where they could be seen if necessary and told us they had done this on many occasions with patients who were extremely anxious or claustrophobic.

- Patient feedback was that staff were very supportive towards them and their relatives and had helped them feel calmer and reassured about the procedure.
- Staff told us that patients could visit the unit prior to their appointment if they were worried about coping with the procedure

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care.**
- We saw staff going through medical history, safety questions and contraindications with patients to ensure they understood what was to happen and that they were aware of any risks to safety.
- Patients were given the opportunity to ask questions or to tell staff if there was anything they did not understand.
- Patients told us staff had explained things well and they understood what was to happen at every stage of their appointment.
- Staff explained what was happening by communicating with patients before, after and throughout the scan.

Are diagnostic imaging services responsive?

Good 

Service delivery to meet the needs of local people

- **The service planned and provided services in a way that met the needs of its patients.**
- The clinic had accessible parking spaces next to the building.
- The waiting area had comfortable seating for six patients and the clinic was accessible to users of wheelchairs.
- Patients were provided with adequate information about their scan and when their results would be available.

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Meeting people's individual needs

• The service took account of patients' individual needs.

- Staff had received training regarding how to support people with a learning disability and people living with dementia.
- The service was accessible to all.
- There was an induction hearing loop available for patients with reduced hearing range and a wheelchair and patient trolley were available to help staff support patients with mobility issues.
- The service could provide information in Braille if needed.
- Patient information guides were available in Arabic, Hindi, Bengali, Polish, Chinese, Punjabi, Gujarati, Urdu and other languages were available on request.
- Interpreter services were available on request and were arranged at point of appointment booking. We were able to speak with a patient during our inspection that had an interpreter with them for their scan.
- There was no explicit referral or acceptance criteria for the service, such as weight which may restrict access to the service because of scanner capability. However, referrers were asked to provide information about any additional needs the patient may have to ensure the service could respond to them.
- Patient information leaflets and frequently asked question sheets also ensured patients were aware that the service would make adjustments or provide extra help for them to access the service.
- The service no longer had its own hoist to assist patients on and off the scan table, this was because it was impractical to have all staff trained to use the equipment and keep skills up to date when it had never needed to be used. Staff felt that if there was an issue that needed this type of equipment to move a patient then they would seek help from staff in the adjacent hospital department.
- There were magazines for patients to read while waiting for their scan, in the main waiting areas.

Patients had commented in feedback that an improvement would be to have something to read in the uptake rooms as it was around an hour waiting from injection to scan.

- For safety reasons whilst a friend, relative or carer could accompany patients to the hospital, they were not routinely able to go with them into the preparation or scanning areas. However, exceptions were made where necessary for example when patients needed translation services or if a patient was extremely distressed.
- Patients were reassured that a member of the team would be watching the scan from the control room and if they had any concerns during the procedure they could communicate with them via a two-way microphone
- Through the patient satisfaction survey one or two patients had suggested that it would be helpful to be able to listen to music when they were in the scanner to distract them from the noise and enclosed space. However, we did not see evidence that this had been actioned.

Access and flow

• People could access the service when they needed it.

- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- In the reporting period October 2017 to September 2018, 3,071 patients attended the
- Referrals were initially received by the trust nuclear medicine admin team, quality checked and entered on their radiology information system. They were then passed to an Administration of Radioactive Substances Advisory Committee (ARSAC) certified radiologist for vetting and triage. They were then passed to the Alliance Medical Limited local bookings team and were entered on the Alliance radiology information system.
- The booking team reviewed the referrals for any specific requirements then contacted the patient via telephone to explain the procedure, complete a safety questionnaire and make the booking.

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- A maximum of two attempts were made to contact the patient by telephone to arrange an appointment then if unsuccessful an appointment was made and sent by letter. This was to minimise any delays in the pathway.
- The referral process allowed for bookings staff to create notes for scans marked as urgent, to ensure these were dealt with as a priority and try to plan for the next operational day, where possible.
- The centre reserved two slots every day for urgent referrals as defined by the radiologist. If the appointments were not requested by 12 noon the day before they were released for less urgent appointments.
- The manager told us that where capacity issues arise, consideration is given to extending days or running an additional list on a Saturday, subject to safe staffing. If necessary they told us consideration is also given to contacting other centres to check for spare capacity
- Staff told us that most patients were given a 30-minute time slot and that this was usually plenty of time. Some scans were expected to take longer and 45 or 60 minute appointment slots were arranged when necessary. Staff told us patients were seen on time and it was rare for patients to have to wait more than a few minutes past their appointment time. This was particularly important as the nuclear medicines given to enable the scan images degenerated very quickly.
- We saw that patients received their scans on time, they were given plenty of time to change and for their scan and were not rushed.
- From October 2017 to June 2018 the average time from referral to scan was under two working days. During this time less than 1% of patients had waited longer than 10 working days for their scan and 75% were scanned within five working days.
- Patients told us that the service was easy to access and they had been given clear information when the receptionist had telephoned them to arrange their appointment.
- From November 2017 to October 2018 there had been no appointments cancelled by the centre for any reason. However, data from the centre showed that from November 2017 to October 2018, 656 appointments were delayed, 127 of these had been

delayed due to machine breakdown or other equipment failure. The most frequent reason given for delays was patient choice. The manager told us that there had been an issue with the supply of the radioactive tracer over a period of a few weeks that had also led to many these delays and resulted in a backlog. The supply issue and backlog of appointments was now resolved.

- There were no current capacity or waiting list issues.
- Sometimes there were delays in transferring inpatients from wards to the department, this could be due to escort availability from the ward or portering delays. Unfortunately, this could sometimes result in a patient needing to be re-booked due to the rapid degeneration of the radioactive tracer used for the scans.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**
- There was a corporate Alliance Medical Limited 'Management of Concerns and Complaints Policy and Procedure' which included a second stage process. If a response to a complaint did not meet the needs of the complainant then they could escalate their complaint to the Parliamentary Health Service Ombudsman or the Independent Healthcare Advisory Service.
- Leaflets were displayed in the reception area which gave information on how to raise concerns or complaints.
- Patient information leaflets contained information about how to make a complaint or give feedback on the service.
- People could also raise concerns through patient satisfaction survey forms which were available to people who had attended for scans, patients were asked if they would mind completing these following their scan and when waiting to go home. They then posted the form in a box in the waiting area.
- Staff told us that anything highlighted as an area for improvement from patient feedback or suggestions

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was actioned if possible. For example, staff were giving information at different times in the patient pathway to help ensure patients knew when and how they would obtain their results.

- The centre had not received any formal complaints from November 2017 to October 2018. Staff told us they had never had any formal complaints but if a patient raised any issues or difficulties with them they would deal with their concern at once.
- The manager told us that lessons learned from complaints across the Alliance Medical Limited group were shared with staff via the Risky Business bulletin which is sent to all staff. We found that complaints from across the Alliance Medical Limited group were analysed for themes and lessons for improvement and this was shared with all units in the annual complaint summary.

Are diagnostic imaging services well-led?

Good 

Leadership

- **The manager of the service had the right skills and abilities to run a service providing high-quality sustainable care.**
- The service was led by the centre manager who was the registered manager for the service. The registered manager had responsibility for the day-to-day running of the centre.
- The registered manager was supported by a regional manager who was a central contact for escalating concerns and risks to the provider-level quality and risk team and for cascading information back to the location managers. The manager told us this was a recent change and had improved communication and support.
- The manager had one to one discussion with the regional manager and attended regular meetings held for all Alliance Medical Limited managers in the North region.

- Staff said they felt supported and that the leaders were approachable, they gave examples of being supported with training and development.

Vision and strategy

- **The service had a vision for what it wanted to achieve.**
- The vision and values for the service had been developed for the Alliance Medical Limited group and included; Collaboration - working together and in partnership for all patients; Excellence - striving to deliver the very best to ensure the highest quality of care; Efficiency - constantly seeking new ways to use resources more intelligently; and Learning – with a commitment to ensuring learning and continuously looking for improved ways of working.
- The aim of the service was to provide high standards of diagnostic imaging to meet the needs of referrers and their patients
- Although there was no formal written development plan or strategy for the unit, the manager had definite ideas from discussions with stakeholders for how the service could be developed. The future vision for the PET-CT centre was to expand the use of the current tracer to facilitate cardiology, neurology and infection imaging applications. The service also wished to broaden the range of tracers offered to support a wider range of patients and to increase research activity.

Culture

- **The manager promoted a positive culture that supported and valued staff.**
- There was a culture where there was an emphasis on promoting patients' privacy and dignity and a desire to provide patients with a high-quality service.
- The service promoted a culture of openness and honesty. Staff felt able to escalate concerns and issues to managers within the service.
- Policies and procedures were in place to guide staff practice and expected behaviours. Policies indicated that any issues, where staff acted outside of policy or displayed inappropriate behaviours, would be taken seriously and dealt with appropriately.

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- Alliance Medical limited had a whistleblowing policy for staff to refer to and had appointed a 'Speak Up Guardian' to help staff if they needed to raise a concern about someone's working practice or patient safety. Staff felt they could raise any concerns they had with the centre manager or the Alliance Medical Limited management team.
- Staff told us they felt listened to, supported and that training and development was encouraged.
- The manager and staff were proud of the team and the service they provided.

Governance

- **The service systematically improved service quality and safeguarded high standards of care.**
- The registered manager had a detailed oversight of the service as they were based at the service location and regularly worked clinically alongside the other staff. The manager was able to articulate any challenges staff members were facing as well as challenges for the service. They demonstrated a good awareness of the key risks to performance, quality and safety within the service.
- The registered manager was familiar with key individuals within Alliance Medical Ltd for advice and support with any issues that arose.
- There was a quality and risk department within Alliance Medical Ltd, which regularly reviewed complaints, incidents and risks and produced a monthly newsletter entitled "Risky Business". Information within the newsletter was discussed at team meetings within the service.
- Local team meetings were intended to be monthly however there had been several months gap due to a period of absence of the registered manager. This had been highlighted on the quality assurance action tracker from the October 2018 audit but had not been reinstated yet.
- The centre manager attended quarterly service review meetings with the trust and service commissioners, which provided a forum to raise or discuss any issues or ideas for development. Incidents and complaints from the centre were also discussed at these meetings.

- Although the manager told us this was going to happen, Disclosure and Barring Services (DBS) checks had yet to be re-done for two members of staff who had last been checked in 2014, to bring this in line with the new policy requirement of three yearly checks.
- There was a system in place to ensure that referrers were approved and were registered with the Health and Care Professionals Council. This was checked annually.
- The Alliance Medical Ltd human resource team ensured that radiologists had indemnity insurance in place and that registration with the General Medical Council was up to date.
- Within Alliance Medical Limited there was a governance and committee structure which ensured performance of the service was monitored, using five key quality indicators: Access; Quality; Turnaround of reports; Safety and Satisfaction (patients and customers).
- There were good systems and processes in place for maintenance of equipment and there were appropriate policies, local rules and protocols in place.
- There was oversight of staff training, competence and relevant staff had current professional registration.
- Although we saw shared learning from incidents and complaints in the newsletter and that they were discussed at team meetings, there had been several months without team meetings to enable discussion and to ensure staff had read and understood the information shared. We also found that although incidents were reported, categorisation of incidents had been inconsistent over the previous 12 months.

Managing risks, issues and performance

- **The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- In addition to the Alliance Medical Limited risk register, the service kept an up-to-date record of all risks which included a risk assessment, mitigations to reduce risks and review dates.
- Although all the risks identified on inspection were documented, the staff exposure risk needed further

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mitigations adding, from the quality assurance review recommendations, such as shielding and consideration to be given to using an auto dispenser where necessary to reduce exposure and radioactive doses to the extremities.

- The service had advice and support from a radiation protection adviser, a radioactive waste adviser and a medical physics expert to ensure risks were reduced to a minimum.

Managing information

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- All staff had undergone information governance training.
- The service was registered with the Information Commissioner's Office through Alliance Medical Limited and there was a named Caldicott guardian.
- There were systems and processes in place to maintain security of information including patient records. There were minimal paper records for patients and these were scanned on to an electronic system for retention and destroyed at the end of an episode of care.
- Information was collected and analysed to monitor and improve performance.

Engagement

- **The service engaged well with patients, staff, the trust and commissioners to plan and manage appropriate services.**
- Patient engagement was ongoing through the use of comments cards from December 2018 to February 2019 there were 71 patient responses, of these 62 patients (87%) were very satisfied and nine were satisfied. Seventy seven percent of patients said they would be extremely likely to recommend the service, 13% of patients said they would be likely to recommend and the rest did not answer this question.
- We saw that patient feedback was taken seriously and actions were taken as a result. For example, a patient had commented that they would have liked more

information about how to get their results and staff had noticed that patients often phoned the centre following their scan trying to access the results of their scan. Because of this staff had changed their practice to ensure that in addition to this information being provided at booking and prior to injection they would reiterate this information to the patients at the end of their scan whilst preparing them a hot drink. Staff had also placed notices in the waiting areas and uptake rooms to inform patients what they needed to do to obtain their results. Following this improvement action staff have noticed a reduction in the number of incoming calls from patients chasing results.

- There were some other suggestions from patients, that did not appear to have been responded to such as; would have like a TV/ music or something to read while waiting in the uptake rooms, information could include to bring warm clothing as it is a bit cool in the uptake rooms, would have liked to be able to listen to music during the scan.
- Alliance Medical Limited also carried out a staff survey, a clinician satisfaction survey and survey for referrers. Unfortunately, we did not see the results of these surveys during the inspection.
- One of the staff told us that Alliance Medical Limited also operates an external employee assistance programme which they had found easy to access.

Learning, continuous improvement and innovation

- **The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.**
- The service through Alliance Medical Limited was fully accredited with the Imaging Services Accreditation Scheme.
- Staff told us that they were provided with opportunities to attend additional training which would help them in their roles. The manager had recently applied to be involved in a graduate development scheme.
- The centre had introduced 4D scanning to give better images of small lung nodules particularly around the diaphragm.

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- The manager told us that the service was developing a service to provide a diagnostic contrast-enhanced CT scan at the same time as the PET-CT. This would reduce the number of hospital visits needed before the start of treatment.
- The manager told us the centre hoped to develop services around cardiology and neurology imaging.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should ensure the risk assessment and mitigations for staff should be revisited to include the findings of recent incident investigations in relations to auto dispensers and shielding. (Regulation 17)
- The provider should ensure incidents are reported and categorised consistently to enable easier identification of themes, trends and areas for learning and improvement. Ensure recommendations from incident investigations are actioned in a timely way. (Regulation 12)
- The provider should reinstate regular team meetings as soon as possible.
- The provider should continue to work through carrying out disclosure and barring service checks for all staff whose check was more than three years ago.
- The provider should consider displaying patient feedback and actions taken as a result, to include any reasons for not being able to progress a suggestion for improvement.
- The provider should consider how the service can work with the trust to ensure inpatients attend their scans on time, to reduce the number of patients having scans delayed because their radioactive tracer has started to degenerate.