Preston PET CT Centre

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

Preston PET CT Centre is operated by Alliance Medical Limited. The service has been providing specialist diagnostic services since July 2007 in a purpose-built facility within a local NHS trust.

The service delivers positron emission tomography-computed tomography (PET-CT) diagnostic imaging services to the Lancashire and South Cumbria region.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 29 July 2019, along with an announced visit to the centre on 1 August 2019.

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

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

The service was last inspected in 2014 and met all the required standards. However, it was not rated under our new inspection methodology.

Services we rate

We rated it as **Good** overall.

We found good practice in diagnostic imaging:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good, clear and appropriate records of patients care and treatment. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent for their roles. Staff worked together for the benefit of the patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patient's individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and responsibilities. The service engaged well with patients and all staff were committed to improving services continually.

We found areas of outstanding practice in diagnostic imaging:

- Feedback from patients was continually positive about staff treating them well and with kindness. Patients we spoke with told us that staff would go the extra mile to make them comfortable; the care and support they received during their procedures exceeded their expectations. For example, the centre was opened out of hours by staff in their own time for a needle phobic paediatric patient so that the patient didn't have to wait over the weekend with a cannula in.
- To improve on best practice, the service had recently implemented a second poster specifically aimed for the IR(ME)R operator checklist for administration of radioisotopes for molecular imaging procedures. Both posters acted as reminders for clinical staff carrying out molecular imaging procedures.
- The service had managers to run a service providing high-quality sustainable care. The leadership, governance and culture of the service was used to drive and improve the delivery of high-quality

Summary of findings

person-centred care. Weekly goals and staff engagement were paramount in all that the service delivered; this not only enhanced patient care but it enhanced the wellbeing of the staff.

- We saw that there was a bereavement box located in the control room. Staff told us they had a bereavement box to prepare for the event that a patient passed away whilst in the centre. Due to the nature of the diseases scanned, patients could be very poorly when they attended. The box contained, clean sheets and gowns and staff felt that by having this box readily available would help families in the bereavement process as they didn't have to wait to obtain items for carrying out last offices from the NHS trust.

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

Anne Ford

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	The service provided specialist diagnostic imaging procedures. We rated it good overall because we rated safe, effective, caring, responsive and well-led as good. The service prided itself on not only being able to cater for patients with anxiety and claustrophobia (fear of confined spaces) due to the additional time allocated for appointments it was also proud that they would and could cater for individual patient needs by opening the centre on an ad-hoc basis when required.

Summary of findings

Contents

Good

Location name here

Services we looked at
Diagnostic imaging

Summary of this inspection

Background to Preston PET CT Centre

Preston PET CT Centre is operated by Alliance Medical Limited. The centre opened in July 2007. It is a positron emission tomography-computed tomography scan service in the grounds of the local NHS hospital. The hospital primarily serves the communities of the Lancashire and Cumbria area. However, it accepts patient referrals from outside this area, both NHS and privately funded.

The hospital has had a registered manager in post since 2011.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,a CQC inspector, and a specialist advisor with expertise in nuclear medicine. The inspection team was overseen by Judith Connor, Head of Hospital Inspections.

Information about Preston PET CT Centre

The service is registered to provide the following regulated activities:

- Diagnostic and screening procedures.

During the inspection, we spoke with 10 members of staff including radiographers, clinical assistants, administration assistants, the registered manager, a radiologist and an Administration of Radioactive Substances Advisory Committee license holder.

We observed patients receiving care and spoke with three patients and four relatives.

During our inspection we reviewed 10 sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service had last been inspected in 2014 and had met all the standards required. However, this inspection was the first time it had been rated using the new CQC methodology.

Track record on safety:

For the period May 2018 to June 2019:

- There were no never events or serious incidents
- There were no incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA)
- There were no incidences of hospital acquired Methicillin-sensitive Staphylococcus aureus (MSSA)
- There were no incidences of hospital acquired Clostridium difficile (C-difficile).
- There were no incidences of hospital acquired Escherichia coli (E-coli)
- There were 17 incidents that were classified as low or moderate harm.

Services accredited by a national body:

- The Imaging Services Accreditation Scheme (ISAS) December 2018 – Ongoing
- ISO 27001, the International Information Security Standard from June 2018 to June 2021
- Investors in People - March 2017 to March 2020

Services provided at the hospital under service level agreement:

- Cleaning services (internal facility only)
- Building maintenance (infrastructure only)
- Interpreting services
- Portering (patient transfers/post/ /deliveries of consumables)

Summary of this inspection

- Laundry
- Resuscitation services
- Waste management
- Telephone system

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Are services safe?

We rated it as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- Staff kept appropriate records of patients care and treatment.
- The service used systems appropriately to administer and record the use of radioactive pharmaceutical agents.
- The service managed patient safety incidents well. Staff recognised and reported incidents appropriately. Lessons learnt were shared across the organisation.

However:

- Oxygen cylinders were stored on the floor next to the resuscitation trolley. In addition to this, two defibrillators were stored on a chair next to the resuscitation trolley.
- Cleaning materials were stored in a cupboard within the dispensing room. However, the cupboard was not locked and the door to the room was left open during clinic hours as there was only one key to the room. This did not comply with the control of substances hazardous to health regulations (2002). We raised this with management and was told that they had requested fob access for this room so that the door would close on exit of the room. We saw the request had been sent off on the 19 July 2019 for a quote and this had been received. This was now awaiting approval for it to be implemented.

Are services effective?

Are services effective?

We currently do not rate effective within diagnostic imaging.

Summary of this inspection

- The service provided care and treatment based on national guidance and evidence-based practice, which included the Administration of Radioactive Substances Advisory Committee and Ionising Radiation (Medical Exposure) Regulations.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings to provide support and development.
- Radiologists, radiographers and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- The centre was opened five days per week, Monday to Friday from 7am to 7pm to support timely patient care.
- Staff we spoke with understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients experiencing mental health and those who lacked the capacity to make decisions about their care.

Are services caring?

Good

Are services caring?

We rated it as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Patients were truly respected and valued as individuals. All were empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service. This was evidenced by providing extra appointment times and practice runs in the scanner for patients suffering from claustrophobia or for those who had a cognitive impairment.
- Feedback from patients was continually positive about staff treating them well and with kindness. Patients we spoke with told us that staff would go the extra mile to make them comfortable; the care and support they received during their procedures exceeded their expectations. Feedback was monitored closely by the service as an outcome of care and treatment provided.
- We saw numerous compliments received within the service, from not only patients, but families, carers and healthcare professionals from the local NHS trust and other NHS trusts.

Summary of this inspection

- Staff provided emotional support to patients, families and carers to minimise their distress.
- Staff involved patients and their families in decisions about their care and treatment.
- We observed staff talking to patients sensitively and appropriately, dependent on the individual need.

Are services responsive?

Good

Are services responsive?

We rated it as **Good** because:

- The service planned and provided care in a way that met the needs of local people and communities served. It also worked with others in the wider system and local organisations to plan care.
- The service took account of patient's individual needs and preferences.
- The service acted promptly on patient feedback and subscribed to a monthly magazine subscription so that the waiting area always had new magazines for patients and families. In addition to this, the service also implemented a 'Meet the Team' board as patients had fed back that they did not know the roles and responsibilities of the staff.
- People could access the service when they needed it and received the right care promptly. There were no waiting lists at the time of our inspection.
- Interpreter services, a portable hearing loop and large font documents for visually impaired patients could be provided for patients and their families. In addition to this, visual guides could be provided for patients with learning difficulties, such as autism.
- It was easy for people to give feedback and raise concerns about care received.

Are services well-led?

Good

We rated it as **Good** because:

- The service had managers to run a service providing high-quality sustainable care. The leadership, governance and culture of the service was used to drive and improve the delivery of high-quality person-centred care.

Summary of this inspection

- We saw the corporate vision, values and governance framework. This was aligned to the Care Quality Commission's key lines of enquiry and staff we spoke with told us that they were aware of the service strategy and felt involved in helping to improve the service
- There was compassionate, inclusive and effective leadership within the service. In addition, there was a positive culture within the service, which focussed on the provision of person-centred care. The registered manager had an inspiring shared purpose and strived to deliver and motivate staff to succeed.
- Governance processes were in place within the service. The registered manager was able to maintain detailed oversight of the running of the service.
- Governance arrangements were proactively reviewed and reflected best practice. The service managed risk well and effectively used a risk register to identify, monitor and mitigate risks.
- The service used both paper and electronic information to support its activities. All staff practised in accordance with General Data Protection Regulations (2018). Information governance was part of the mandatory training and all staff were 100% compliant.
- The service used patient surveys to collect feedback. We reviewed the feedback and found that all patients were positive about the centre. For example, one patient wrote 'such professional staff, extremely knowledgeable and professional from the moment I got the appointment to being sat in the waiting room after my scan, credit to the department and everyone that dealt with me'; another example was 'an obviously well practised team who made the whole session relaxing; a very reassuring manner in all and everyone had smiles, thank you' We did not see any negative comments about staff or the service.
- The service promoted continuous learning. Staff we spoke with told us that they were provided with opportunities to attend additional training for their development. For example, the new full time graduate that the service had recently employed and been offered training to complete their post-graduate certification in radiography and had also been given the opportunity to work at other sites to enhance their knowledge in other areas.

However:

Summary of this inspection

- At the time of inspection, we were not assured that the calibration of the workstation that was used in emergencies for the reporting of diagnostic images was completed. This meant that the service could not confirm that quality assurance checks were performed by the external supplier. Following the inspection, the service confirmed that the equipment had been serviced and calibrated on 30 August 2019.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

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.**
- Compliance targets for the service were 100%. The registered manager completed mandatory training figures for submission to senior management on a weekly basis. This was to ensure that the service was proactively maintaining and updating mandatory records. If staff were not compliant then reasons for non-compliance and actions for improvement had to be completed.
- Staff received mandatory training on key topics, for example, health and safety, information governance, equality and diversity, moving and handling and prevent. The Counter Terrorism and Security Act 2015 introduced Prevent training to help stop vulnerable people from being exploited and drawn into terrorism.
- Administration staff received basic life support training and were fully compliant.
- Clinical staff received adult and paediatric intermediate life support training and were fully compliant.

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.**
- Mandatory training included safeguarding training. All staff were 100% compliant for safeguarding adults and children level one. In addition to this, all clinical staff received training in safeguarding adults and children level two and level three. This was in line with the standards set out by the intercollegiate document, safeguarding children and young people: roles and competencies for healthcare staff (2019).
- There were safeguarding policies in place. We saw a safeguarding adult's policy and a safeguarding children's policy, both of which were in date. Flowcharts were included within the policies on how to raise concerns. In addition to this, a poster was displayed with contact numbers in each area on how to raise a safeguarding concern.
- Staff were aware of their roles and responsibilities in safeguarding and knew how to raise a concern appropriately. Staff we spoke with told us that if they had a safeguarding concern they would also share it with the NHS trust the site was located on so that information identified could be shared.
- There had been no reportable safeguarding incidents within the service for the period May 2018 to June 2019. However, staff told us that they had recently had concerns for a patient's welfare and information had been shared with their GP and the safeguarding team at the local trust so that the patient could be monitored.
- Safeguarding leads were available locally and regionally for support for adults and children. The organisations child safeguarding lead was trained to level four.
- A chaperone policy was in place and a poster displayed in the waiting area to ensure that patients and their relatives were aware of this service. Patients and relatives, we spoke with were aware of this service and would use it if required.

Cleanliness, infection control and hygiene

Good

Diagnostic imaging

- **The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- We observed that clinical, public and staff areas were clean, tidy and free from clutter.
- Personal protective equipment, including gloves and aprons were available in all clinical areas. Posters demonstrating 'hand hygiene techniques' were displayed throughout the centre.
- There were hand gel sanitizers available in all areas. We observed staff using the hand gel before and after providing patient care. All staff we observed were bare below the elbow when treating patients.
- Hand hygiene audits were completed monthly and compliance demonstrated 100% every month in the period May 2018 to June 2019.
- The service had daily cleaning schedules which were displayed on a white board outside the scanning room. The service was cleaned by domestic cleaning staff daily under an arrangement with the host NHS trust. The unit manager monitored performance and provided feedback on required actions. An annual deep clean contract was in place under a corporate contract.
- Infection prevention and control was included in the mandatory training for staff. All staff were 100% compliant.
- There was an infection prevention and control lead within the service and they could be accessed daily if required.
- We reviewed an audit on the insertion of peripheral vascular devices which demonstrated 100% compliance every month in the period May 2018 to June 2019.
- Sharps bins were available in all clinical areas, including dedicated bins to collect radioactive sharp waste; all were dated and secure. The dedicated sharps bins were typically retained for 24 to 48 hours due to the short radioactive half-life of isotope used; these were removed after checking with the radiation contamination monitor for absolute assurance that sharps bins no longer contained radioactive material. Linen was also checked with the radiation contamination monitor before being collected by the portering staff at the host NHS trust.
- There were no incidences of hospital acquired methicillin-resistant Staphylococcus aureus (MRSA), methicillin-sensitive Staphylococcus aureus (MSSA), clostridium difficile (C-difficile) or Escherichia coli reported by the service for the period May 2018 to June 2019.
- Legionella testing was carried out in line with the host NHS trust policy.
- Staff told us that patients who presented with a communicable disease would be discussed with the infection prevention and control lead and staff in the infection control team at the host NHS trust. If advised, the patient would be allocated an appointment at the end of the list for the day's appointments.
- We saw the annual infection prevention and control audit carried out by the provider which saw the centre achieve a score of 95% against a benchmark target of 90%.
- Clinical areas had flooring which was washable and compliant with the Department of Health building note (HBN 00-10).
- Cleaning materials were stored in a cupboard within the dispensing room. However, the cupboard was not locked and the door to the room was left open during clinic hours as there was only one key to the room. This did not comply with the control of substances hazardous to health regulations (2002). We raised this with management and was told that they had requested fob access for this room so that the door would close on exit of the room. We saw the request had been sent off on the 19 July 2019 for a quote and this had been received. This was now awaiting approval for it to be implemented.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.
- The centre was in a purpose-built facility within the local NHS trust.
- Fire exits were clearly signposted. Fire break glass points were observed at each exit which complied with the Fire Industry Association BS EN 54-11:2001. A review of all fire extinguishers within the centre were in date with their annual service.

Good

Diagnostic imaging

- Facilities within the centre where patients and staff could access without restrictions, included a reception area, waiting area and two toilets (one for visitors and one for staff). Both toilets had disabled access.
- Restricted access facilities for staff only, included, a main office, managers office, reporting room, holding area with stretcher, control room, scan room, three injection rooms, one changing room, dispensing room, store room and two toilets (one 'hot' toilet and one 'hot' disabled toilet).
- The reporting room consisted of three work stations; a workstation permitting remote tele reporting; a diagnostic workstation facilitating PET image review and a picture archiving and communication system workstation owned by the host NHS Trust. When we spoke with staff, we were told that predominantly the picture archiving and communication system would be used, however there was a business continuity plan in place so that on occasions for comparative review of PET source data or when the trust picture archiving and communication system experienced downtime; the other workstation could be used for reporting.
- There was clear signage that included no entry signs in controlled areas where radiation was administered. Signage was also evident on the radioactive waste cupboard within the dispensing room.
- All staff had personal thermoluminescent dosimeters monitors to measure radiation doses.
- Specialist protective equipment, for example, lead aprons were available from the host NHS hospital nuclear medicine department if required. However, management told us that this was a rare occurrence and they had not required use of these aprons for the previous seven years.
- Environmental temperature checks were completed daily within the dispensing room. We noted that there were no range levels indicated. The service told us that if temperatures went above 30 degrees centigrade then the radiopharmaceutical agent could not be used. No temperatures had exceeded this measurement.
- The service had maintenance arrangements for the service of specialist equipment. All equipment included evidence of a maintenance check within the last 12 months. The centre was supported by the medical physics department at the host NHS trust.
- There was a process for checking equipment and reporting any faults or concerns. Staff we spoke with were confident in how to report faulty equipment.
- We saw that there was a new music system that had been purchased in October 2018 without safety electrical testing stickers in place. This was raised with management at the time of inspection and we were told that all portable appliances would be checked on the next safety electrical testing visit on 1 August 2019.
- We reviewed a sample of sundry items, for example, syringes, pre-filled normal saline syringes and sterile gauze. All were in date and stored appropriately.
- Seating within the waiting area had a selection of low and high-backed chairs for patient comfort. All were wipeable and compliant with the Department of Health building note (HBN 00-09).
- Emergency resuscitation equipment for both adults and paediatrics, was available in the centre. The contents were secured with a number tagging system. Daily checks were carried out and we saw the schedules to confirm that this had taken place. An emergency anaphylaxis kit was stored on the resuscitation trolley. Oxygen cylinders were available next to the resuscitation trolley, but they were on the floor and not stored securely. In addition to this, the service had two portable defibrillators that were stored on a chair next to the resuscitation trolley. We raised this was with management at the time of inspection and were told that following our inspection they would look at putting shelving on the wall to store the oxygen and defibrillators.

Assessing and responding to patient risk

- There were dedicated 'hot' toilets that were allocated for patients who had received the radioactive pharmaceutical agent. These toilets had clear signage for patients and relatives and posters displayed to remind patients that their urine would now be radioactive. Hot toilets were toilets that were dedicated to patients who had received the radio pharmaceutical agent.
- Staff confirmed the identity of patients on arrival to the centre. Patients personal details, for example, name, date of birth and address, were checked at point of entry to the centre.
- Staff carrying out diagnostic imaging used a 'pause and check' checklist which helped to ensure that the right patient received the right scan at the right time.
- Pause and Check posters were displayed in injection rooms and the scanner/control room. The service currently used and followed a pause and check poster

for the IR(ME)R operator checklist for molecular imaging procedures: image acquisition. However, to improve on best practice, the service had recently implemented a second poster specifically aimed for the IR(ME)R operator checklist for administration of radioisotopes for molecular imaging procedures. Both posters acted as reminders for clinical staff carrying out molecular imaging procedures. Staff we spoke with told us that they were not only beneficial for staff and patient safety, they were a great resource to have displayed within the clinical areas.

- In addition to the pause and check posters, we observed another poster displayed called the 'Nuclear Medicine Tests' that had been released nationally in May 2019. This document provided an explanation to patients about the small risk from radiation that could be received from specific imaging procedures. This poster helped with the 'risk versus benefit' discussion between staff and the patients. It also supplemented what the referring clinician and the radiographer could advise.
- We observed staff confirming the patient's personal details before administration of any radioactive pharmaceutical agent and again before completing the scan. All female patients aged 12 to 55 were asked if they could be pregnant and they had to sign a form to confirm if they were not. If patients thought, they may be or were pregnant then another form called 'statement of exclusion of pregnancy' form was completed.
- Staff we spoke with told us that in the event they found any unexpected or unusual findings during the scanning procedure they would report it to the radiologists who would then contact the referring clinician if required. We reviewed a flowchart for staff on significant findings procedure. This was concise and easy to follow.
- All staff wore thermoluminescent dosimeter devices. These devices were personal radiation detection devices measuring the amount of radiation exposure staff had been exposed to. Staff personally documented these levels daily and investigations and actions were carried out by the registered manager if levels were above the dose limits. Dose limits were set by the Health and Safety Executive (HSE) to protect workers and members of the public from the effects of ionising radiation. We reviewed the dosimeter records and saw that one member of staff's dose level had been close to the dose limit and this had been flagged to the registered manager. The service carried out an investigation into the reason, which demonstrated that the individual was new to the role and had been covering a colleague whilst on maternity leave. Actions had been put in place for further training.
- Staff we spoke with knew how to escalate concerns about a deteriorating patient. There was a management of medical emergency, policy and procedures guidelines in place as well as a service level agreement with the host NHS trust for the transfer of patients.
- All clinical staff were trained in adults and paediatric intermediate life support. This was in line with the service requirements and aligned to the Resuscitation Council (UK) guidelines. The host NHS hospital provided resuscitation equipment and an emergency response team if required.
- Call bells were available in the injection rooms for patients to call for staff if required. These were always answered promptly. Following the administration of the radioactive pharmaceutical agent, patients were asked by staff to lie down and relax and to keep as still as possible for one hour so that the medicine could absorb equally within the body and not absorb into their muscles.
- We saw that each injection room had closed circuit cameras for staff to monitor patients. These cameras did not record images and patients were told why they were in place. Posters were displayed to tell patients that they were for safety reasons only.
- Before patients entered the scanning room, patients were asked to remove any metal objects, such as spectacles or watches. Women were asked to remove their bras if they contained metal and gentlemen were asked to remove their trousers if they had zips.
- There were clear processes in place for patients with diabetes. Appointments were booked four hours after the patients had received their insulin and a light snack.
- The radiation protection supervisor based at the centre was supported by a radiation protection advisor. In addition to this, we were told by staff that support was given by the radiologists at the NHS trust.
- There were local rules and employers' procedures in place, which protected staff and patients from ionising radiation. The local rules included details of authorised persons, mapped controlled areas and labelling of equipment.

Staffing

Good

Diagnostic imaging

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.**
- Staffing was assessed using a staffing calculation tool that was in line with the corporate policy on staffing requirements in support of a safe scanning pathway. The tool was used to determine the staffing levels required for the facility based on the number of operational hours.
- The service employed 3.75 full time equivalent radiographers, 1.25 full time equivalent clinical assistants, 2.5 full time equivalent administrators and one 0.5 full time equivalent manager.
- There was one full time equivalent radiographer vacancy post which accounted for 0.6 of the staffing headcounts. Management had made the decision to recruit a whole time equivalent graduate radiographer to coincide with the growth of the service.
- All staff were required to complete an induction process. This included any bank staff that may be used to cover sickness and holidays.
- For the period April to June 2019 there were no staff sickness for radiographers. However, in this period there was an average rate of 0.2% for clerical assistants. Bank staff were used to cover shifts. Agency staff were never used as this was a condition of the local contract.
- A notice board was in the waiting area which displayed staff photographs and their roles within the service.
- Structured daily huddles took place before patients arrived. Examples of discussions that took place were appointments, referrals, risks and incidents.

Medical staffing

- The unit was supported by Fellowship of Royal College of Radiology (FRCR) accredited reporting radiologists that were employed by the host NHS trust.
- The service had one radiologist that worked under practising privileges. They did not report on any NHS scans but only private scans that took place occasionally.

Records

- **Staff kept appropriate records of patients care and treatment. Electronic records were clear, up-to-date and easily available to all staff providing care.**
- All records were kept securely in areas restricted to staff access only.
- We reviewed the records for 10 patients. Referral forms and patient data forms were clear, legible and completed appropriately.
- We reviewed the records management policy that had a review date of December 2018. We raised this at the time of inspection and was told that it was currently under review with the head of governance for the provider. We also reviewed the patient identification and justification of request policy, which was in date.
- Management told us that data retention was 10 years. This was documented in the contract between the provider and the host NHS trust. However, management told us that oncology records must now be kept for 30 years, thus superseding the contract details. We reviewed the corporate retention schedule which provided details on oncology records to be retained for 30 years. A new contract between the trust and the service was being drafted during our in inspection.
- The service had agreed arrangements in place to enable electronic referrals and reporting information to be shared between the host NHS trust and Alliance Medical Limited systems. 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.
- Information sharing between Alliance Medical and other organisations adhered to agreed protocols/guidance. The Alliance Medical Limited 'Image transfer and case management team' managed IT processes and security centrally.

Medicines

- **The service used systems appropriately to administer and record the use of radioactive pharmaceutical agents.**
- Radioactive pharmaceutical agents were administered under the authorisation of the Administration of Radioactive Substances Advisory Committee (ARSAC) license holder or their delegate as appropriate.
- Records were maintained for staff authorised to administer radioactive pharmaceutical agents.
- Radioactive pharmaceutical agents were prepared at a facility within the NHS trust. However, during our inspection the NHS trust facility was under refurbishment and we were told by management that it

would not be up and running for approximately another four months following our inspection. In the meantime, radioactive pharmaceutical agents were being transported from an external facility in Staffordshire.

- The radioactive pharmaceutical agents could degenerate quickly, therefore stocks were ordered on a named patient basis and delivered daily. Stocks were stored securely within a designated room, in line with the manufacturers' recommendations, to ensure that they would be fit for use.
- There were no controlled drugs kept in the centre.
- Medicines management was in accordance with company policy. The provider had an appointed pharmacy advisor who supported national requirements.
- There were clear processes facilitating the administration of radiopharmaceuticals under ARSAC licensing.
- A radioactive medicine, flurodeoxyglucose (FDG) was given to patients intravenously as a tracer for the PET-CT scan. The scan used a small amount of the medicine to show differences between healthy and diseased tissue.
- All staff including assistants, completed training in medicines management as part of the mandatory training process.

Incidents

- **The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**
- Staff we spoke with told us how they would report incidents via the electronic incident reporting system.
- There were no never events or serious incidents in the period May 2018 to June 2019.
- There were no Ionising Radiation (Medical Exposure) Regulation incidents in the period May 2018 to June 2019.
- Between the period May 2018 to April 2019 there were 17 incidents reported. Fourteen were graded as low risk and three as moderate risk. Of the 17, three were classed as near misses, three as unknown, one as moderate, short term harm and the remaining 10 were classed as none or low (minimal harm caused). Examples of three incidents reviewed were: a low risk item that demonstrated procedure failure or error; a moderate risk item where there was a lost or non-return of a thermoluminescent dosimeter (TLD) and a further low risk item where a patient became unwell during the procedure. Actions taken, and lessons learned were evident and shared with staff and the wider service within the provider.
- Staff we spoke with understood the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- The registered manager had completed training in root cause analysis. We were told by the manager that only managers within the provider completed this training.
- We reviewed presentations given over the previous six months by the operations board and the UK supervisory board. All presentations demonstrated sharing of knowledge and learning following incidents.

Are diagnostic imaging services effective?

We do not provide a rating for effective when we inspect diagnostic imaging services.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence-based practice.** This included the Administration of Radioactive Substances Advisory Committee and Ionising Radiation (Medical Exposure) Regulations.
- Policies and procedures were followed and staff we spoke with told us that these were easy to access online if required. We reviewed a sample of policies; all were within their review date and made references to relevant safety regulations where applicable.
- Each policy had a sign off sheet so that staff could confirm that it had been read and reviewed by each member of staff. These were held in a hard copy site file for easy access.

- The registered manager attended service review meetings with the host NHS hospital where key performance indicators (KPI's) were reviewed and outcomes discussed at unit meetings as appropriate.
- The registered manager was chair of the national advisory group and had been instrumental in the implementation of the new pause and check poster for the IR(ME)R operator checklist for administration of radioisotopes for molecular imaging procedures. The registered manager told us that being part of this group was great for keeping up-to-date with current evidence-based practice.
- The registered manager was booked onto a study day in November to look at hybrid imaging and molecular radiotherapy.

Nutrition and hydration

- Patients were sent letters from the referring clinician with instructions about fasting before the scan.
- Hot and cold refreshments were available in the waiting area for patients and their families.
- Patients were encouraged to drink water in the waiting area to support the radioactive pharmaceutical agent uptake.
- Following the procedure, patients were offered a hot or cold drink before they left the centre.

Pain relief

- Patients with chronic or acute pain were advised to take any prescribed analgesia prior to attending their appointment.
- Prior to getting on the scan table, staff asked the patients if they had any pain and if so, staff would take care to position them comfortably before the procedure commenced.
- If the patient was an inpatient at the host NHS trust, the national early warning score chart was looked at to see if the patient had triggered a pain score.
- There were no pain relief medications stored in the centre.

Patient outcomes

- **Staff monitored the effectiveness of care and treatment. They used the findings to make improvements.**
- Performance was monitored monthly within the service which focused on areas such as incident reporting, training compliance, patient satisfaction and complaints.
- Reporting of the scanned images were completed by the radiologists in the NHS trust. We saw in the current contract with the NHS trust that they had a key performance indicator of two hours for the images to be sent to the trust. This was being achieved. In addition to this, reporting was audited by the Alliance Medical Ltd case management team monthly and any discrepancies were highlighted and communicated back to the reporters.
- The service monitored their key performance indicators. The turnaround time for scans from a referral form being signed and approved to a report being completed was seven working days. This was the same target as the national England target and the service was achieving these targets. However, due to the challenges the service faced in November 2018 with significant fludeoxygluose (FDG) failures, the service prioritised and extended days and weekend working to achieve a turnaround measure of 93%.
- We reviewed a bi-annual audit on the review of image referral quality. This had been carried out in February 2018 by the unit manager. All findings demonstrated that quality of images was good.
- A monthly quality assurance audit on the review of image report accuracy (10% audit) was performed by an independent external radiologist in the UK. This ensured that bias was eliminated. In addition to this a quarterly audit on the review of image quality and patient positioning was also carried out by an external auditor radiologist in the UK. Any discrepancies or technical matters were fed back to the service and the NHS trust's radiology department. This was evidenced with the production of statistical data and analysis.
- The service participated in the Imaging Services Accreditation Scheme and was a fully accredited service at the time of our inspection.

Competent staff

- **The service made sure staff were competent for their roles.** Managers appraised staff's work performance and held supervision meetings to provide support and development.
- All staff had received an appraisal for the period May 2018 to June 2019.

Good

Diagnostic imaging

- We reviewed two radiographers staff competency files which included competencies to be able to carry out their roles. This included completing daily maintenance checks, operating the scanner, administration of radioactive pharmaceutical agents and training equipment logs. All were dated, signed and had review dates.
- We reviewed the Health and Care Professions Council (HCPC) register and saw that all the radiographers were registered to practice. In addition to this, we noted that all staff had a post graduate qualification in radiology. The service told us that the new graduate employee would be given the opportunity to obtain this qualification.
- All staff had to complete medical devices assessment to be able to operate the scanner. We saw evidence of this in the staff competency files that we reviewed.
- We reviewed the local induction checklist that all staff had to complete to carry out their roles. This included items such as, resuscitation procedure, radiation safety, mandatory training and physical security arrangements.
- All bank staff had to complete local induction and complete e-learning on the same modules as expected for permanent staff
- All bank staff had to complete intermediate or basic life support training as required for their role.
- All clinical staff held the good clinical practice certification which allowed them to participate in any clinical research trials the service was involved in.
- Medical staff participated in regular learning and educational meetings. This enabled opportunities from group learning from significant events with focused feedback provided to individuals.

Multidisciplinary working

- **Radiologists, radiographers and other healthcare professionals worked together as a team to benefit patients.** They supported each other to provide good care.
- The service held monthly staff meetings in which all healthcare professionals within the service attended.
- There was effective external team working with the host NHS trust. Consultant radiologists who reported on the diagnostic images were available to staff for support at any time.
- Managers met regularly with the host NHS hospital to review service performance and this was fed back via staff meetings at the centre.

Seven-day services

- The centre was open five days per week, Monday to Friday from 7am to 7pm to support timely patient care.
- The centre occasionally opened on Saturdays if capacity and demand was required.

Consent and Mental Capacity Act

- **Staff we spoke with understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients experiencing mental health and those who lacked the capacity to make decisions about their care.**
- If patients lacked capacity, staff told us that decisions would be made in the best interests of patients; which would involve the patient's representative and other healthcare professionals. However, unless the patient's representative had written proof of power of attorney, they could not consent for the scan to go ahead.
- There was a consent policy available online which was within its review date and in line with current legislation.
- We observed staff obtaining verbal consent from patients before providing any care or treatment.
- All patients were required to sign a consent form prior to any diagnostic procedure. This was documented on the patient data form.
- The service treated children and staff we spoke with were aware of Gillick competency and Fraser guidelines. Gillick competency and Fraser guidelines help people who work with children to balance the need to listen to children's wishes with the responsibility to keep them safe.

Are diagnostic imaging services caring?

Good

This service had not previously been rated. We rated it as **good.**

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- Feedback from patients was continually positive about staff treating them well and with kindness. Patients we spoke with told us that staff would go the extra mile to

make them comfortable; the care and support they received during their procedures exceeded their expectations. Feedback was monitored closely by the service as an outcome of care and treatment provided.

- We reviewed feedback received from a consultant based at a children's NHS hospital thanking staff in the service for their great teamwork in accommodating a paediatric patient out of hours. The child was needle phobic, so the team opened the service on a Saturday just for them so that they did not have to wait with the cannula in over the weekend and could get their scan results in time for treatment to commence.
- We saw numerous compliments to staff in the service, for example, one compliment from a staff member in the host NHS trust read 'if you were on social media , I'd rate you a five' and another from a staff member in another trust read 'just wanted to say thanks for the hard work in getting the recent PET reports through given the high numbers this week, I appreciate all the work that you do'.
- We observed three patient appointments during our inspection and found that staff were polite and friendly towards all the patients. All staff introduced themselves and spoke clearly to ensure patients fully understood why they were attending the centre and what would happen whilst they were there. Patients were also given time to answer questions and ask any questions they may have had regarding the procedure.
- Patients were offered a chaperone if required. The service would try to accommodate the same sex chaperone, but this could not always happen.
- There were three private rooms for patients waiting for their injections. This not only ensured that their privacy and dignity was maintained it also ensured that they could relax properly and not be disturbed.
- We spoke with four patients' relatives who told us that all staff had been courteous and friendly. They also told us that they were made aware of the timescales of the appointments and could help themselves to hot and cold refreshments within the waiting area or attend the NHS trust restaurant or café for food.
- We reviewed the patient satisfaction results which included both adult and paediatrics for April, May and June 2019. Patients could state whether they received excellent, good, satisfied, below average or poor care. In April, 194 patients were scanned, 90 surveys completed with a response rate of 46%; 96% rated excellent care and 4% good. In May, 267 patients were scanned, 126 surveys completed with a response rate of 47%; 94% rated excellent care and 6% good and in June, 225 patients were scanned, 83 surveys completed with a response rate of 37%; 98% rated excellent care and 2% good.
- Examples of comments received, were 'very reassuring, lovely staff'; 'I can't fault anything'; 'very professional and helpful throughout the whole experience' and 'as a very nervous patient, staff made me feel relaxed and comfortable'.

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress.**
- Staff told us that all patients, including children could be offered an extra appointment to visit the centre if they were worried about how they would cope in the scanner. Children were accompanied by a specialist children's nurse for support and older children would usually come to the centre with a parent or guardian.
- Patients who suffered from claustrophobia were given time to lie in the scanner before the actual procedure commenced. Patients were also encouraged to attend the centre the day before their scan to have a practice run of the procedure. Staff told us that if the appointments were fully booked, they would ask the patients to attend at the end of clinic and they would stay open while they carried out the practice run. Patients would also be offered eye masks to help them relax during the scanning procedure.
- Staff we spoke with told us how they supported patients within the scan room, for example, if patients were nervous or anxious. A chaperone was offered or a relative or carer could stay in the room with the patient if required. The local rules allowed this to occur and safety protection equipment was always available. Lights were turned off and lamps used in the injection rooms to help create a calm setting within the room, so patients could relax.
- Music was available for patients to help them relax whilst in the injection rooms. Music was also available whilst in the scanner.
- We saw that there was a bereavement box located in the control room. Staff told us they had a bereavement box to prepare for the event that a patient passed away whilst in the centre. Due to the nature of the diseases scanned, patients could be very poorly when they

attended. Sadly a few years prior to the inspection, a patient had passed away in the clinic; learning from this had resulted in the service implementing the bereavement box.

- The bereavement box contained, clean sheets and gowns and staff felt that by having this box readily available would help families in the bereavement process as they didn't have to wait to obtain items for carrying out last offices from the NHS trust. Last offices are the laying out procedures to the body of a person shortly after death has been confirmed. We spoke with staff about the different cultures and were told that the bereavement team within the trust were a great resource and help if they had any concerns in relation to this.
- There was staff training available in November 2019 for managing patient conversations. Staff we spoke with welcomed this training,

Understanding and involvement of patients and those close to them

- **Staff involved patients and their families in decisions about their care and treatment.**
- A patient information leaflet was sent out to all patients, explaining the procedure before their appointment.
- We observed staff talking to patients sensitively and appropriately, dependent on the individual need.
- Patients and families, we spoke with told us that staff gave them information in a manner that they understood.
- Staff spent time with each patient prior to their scan. The patients' medical history, safety questions and contraindications were discussed to ensure that they understood the whole procedure. Patients were encouraged to ask questions and confirm their understanding of PET-CT scan procedure.
- Patients were advised that the results of their diagnostic images would be sent back to their referring consultant.

Are diagnostic imaging services responsive?

Good

The service had not been previously rated. We rated it as **good.**

Service delivery to meet the needs of local people

- **The service planned and provided care in a way that met the needs of local people and communities served.** It also worked with others in the wider system and local organisations to plan care.
- Patients could be inpatients from the host NHS hospital, outpatients or inpatients from other NHS trusts that were contracted to use the service.
- The service was in the grounds of an NHS hospital and a service level agreement was in place for a range of ancillary services, including waste management, infection prevention and control and resuscitation.
- The waiting area in the clinic was clean, spacious and had adequate seating available for patients and their families. There were a range of low and high-backed comfortable chairs. The area had wheelchair access and ample room to transport patients on stretchers.
- Although the waiting area was adequate for patients and their families there was no dedicated area for paediatric patients.
- The waiting area had hot and cold drinks available for patients and their families.
- A television was on the wall in the waiting area and magazines were available for patients and their families. These were changed monthly following patient feedback.
- Patient information leaflets were available in the waiting area and could be printed in other languages if required. Leaflets we reviewed were only available in English. We raised this with management who told us they would take this to the provider's senior management following our inspection.
- A patient information file was in the waiting area, this included information on what to expect from the scan; pictures and descriptions of the machinery and frequently asked questions. Patients and relatives, we spoke with told us that this file was a great resource.
- There was a restaurant and a café in the host NHS trust which was accessible to patients and their families.
- There was enough parking within the NHS trust for patients and their families.
- Staff and patients accessed the centre by entering the NHS trust. The centre was signposted well and was easy to find.

Meeting people's individual needs

Good

Diagnostic imaging

- **The service took account of patient's individual needs and preferences.**
- A portable hearing loop was available for patients with a hearing impairment.
- Interpreter services were available for patients whose first language was not English.
- Large font documents could be printed for visually impaired patients. In addition to this, visual guides could be provided for patients with learning difficulties, such as autism, these had more photographs in them to prepare for the visit to the centre.
- All areas of the clinic were accessible for wheelchair users and patient stretchers.
- Appointments could be tailored to ensure viewing the scanner for claustrophobic patients could take place prior to injection.
- A detailed folder was available in the waiting area which demonstrated with words and pictures on the scanning process.
- There was a dementia lead within the service who could provide additional support or advice to staff in meeting the needs of people living with dementia when required. All staff had completed training in dementia and delirium which was held externally at an NHS trust.
- The service catered for bariatric patients. The scanner had an adequate table load limit and a large gantry aperture. Large gowns were also available for use when required.
- 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 uptake/injection rooms. However, exceptions were made where necessary, for example, a parent could accompany a child, an extremely distressed patient or an interpreter could attend if required.
- Patients were reassured that a member of the team would always be watching the scan from the control room. If the patient had any concerns during the procedure, they could communicate to each other via a two-way microphone.

Access and flow

- **People could access the service when they needed it and received the right care promptly.**
- Referrals for adults and children were received via secure email from the host NHS trust. These were then printed and provided to the radiologist for vetting.
- There were no waiting lists at the time of our inspection. Nine patients had to be cancelled on the first day our inspection due to a power cut at the facility where the radioactive pharmaceutical agents were made. However, these patients were prioritised according to need and booked in within the month. Management told us that opening times could be extended or services opened at weekends if required in emergency situations.
- Between the period May 2018 and April 2019, 2,462 patients were scanned in the service. 2,415 were NHS patients, 11 private patients and 36 children.
- In the same period, there were 153 patients that did not attend, and 10 scans were cancelled. Cancellations were for either clinical or non-clinical reasons, for example, a clinical cancellation we reviewed was due to a patient's high blood sugars and a non-clinical cancellation was due to the fludeoxyglucose (FDG) not being available. All cancellations were re-booked.
- Patients were seen within seven days of the referral being signed off by the Administration of Radioactive Substances Advisory Committee license holder. Patients' who required urgent cancer appointments were scanned within two weeks of referral.
- The service dealt with the referral process and wait times. Reporting of diagnostic imaging was completed by the NHS trust that the service was sub-contracted with. Key performance indicators were the responsibility of the trust for scanned images.
- Staff opened the centre on an ad hoc basis if required. In addition to this, staff opened the centre in their own time if required.

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.**
- It was easy for people to give feedback and raise concerns about care received.
- The service had not received any complaints for the period May 2018 to June 2019.
- Complaints handing, and conflict resolution was part of the staff mandatory training. All staff were 100% compliant with this.
- We saw a corporate management of concerns and complaints policy and procedure that was in date.

Good

Diagnostic imaging

- Patient leaflets were available in the waiting room which gave guidance on how to give compliments, concerns or complaints on any aspect of the service.

Are diagnostic imaging services well-led?

Good

This service had not previously been rated. We rated it as **good.**

Leadership

- **The service had managers to run a service providing high-quality sustainable care.** The leadership, governance and culture of the service was used to drive and improve the delivery of high-quality person-centred care.
- There was a clearly defined management structure and staff we spoke with knew who they reported to and who the senior management team were. Staff also told us that they were well supported by their managers.
- The registered manager had day to day responsibility for the running of the service. The regional operations manager who was a central contact for support, escalating concerns and risk to the provider-level quality and risk team was available daily for the registered manager.
- The registered manager had regular contact with the regional manager and attended regular meetings held for all Alliance Medical Limited managers in the North region.
- Weekly important goals (WIG's) were set weekly by managers at each location and were discussed on conference calls with managers across locations every Friday morning. Following the success of these the registered manager in the service saw the benefit of completing this within the team. We saw monthly goals displayed on a whiteboard in the staff team room. Each staff member had to focus on one work focused goal and one wellbeing goal every month. For example, a work focused goal was to get some extra cannulation practice and wellbeing goal was to cycle to work. Staff we spoke with told us that this had been a real boost to morale and the initiative was not just focused on workload but also brought in a bit of fun to their working lives.
- A quarterly brief form, the 'UK Managing Director One Team' was shared with the team, this allowed the opportunity for all staff to feedback areas they thought were important to them and to support the service. Staff told us that these forms were great as they could put ideas forward to the wider service.
- The registered manager continued to work occasional clinical shifts to maintain their clinical and skills competencies. This also enhanced great teamwork.

Vision and strategy

- **The service had a corporate vision for what it wanted to achieve.**
- We saw the corporate vision, values and governance framework. This was aligned to the Care Quality Commissions key lines of enquiry and staff we spoke with told us that they were aware of the service strategy and felt involved in helping to improve the service
- The service used the annual internal annual quality assurance review process to identify areas for service development, as part of Alliance Medical Limited's national PET-CT contract.
- Although there was no formal local strategy for the centre, the service was looking to develop contrast enhanced CT-PET which would help to reduce patient turnaround time on cancer pathways for key referral groups; with a specific focus on oesophageal cancer patient pathways.
- We reviewed the business continuity plan which was an agreed process to ensure the continuation of critical functions in the event of a major disruption. In addition to this we reviewed the business continuity policy, which was in date.

Culture

- **There was a positive culture within the service and a sense of common purpose based on shared values.**
- The service focussed on the provision of person-centred care. The registered manager had an inspiring shared purpose and strived to deliver and motivate staff to succeed.
- The service promoted a culture of openness and honesty. Staff we spoke with told us they felt confident in escalating concerns and issues to managers within the service.

- Staff we spoke with were aware of their roles and responsibilities in relation to duty of candour. There had been no incidents which met the requirements for application of duty of candour in the 12 months prior to our inspection.
- All staff we spoke with were passionate about the service and felt proud to be working for the company.
- There was a positive attitude between staff. It was evident that staff supported each other, and staff reported great collaborative team working.

Governance

- **The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.**
- Alliance Medical Limited operated a comprehensive clinical governance framework and we saw that clear governance processes were in place within the service. The registered manager was able to maintain detailed oversight of the running of the service.
- The medical director had overall responsibility for quality and risk within Alliance Medical Limited. The operations structure confirmed a medical director, two directors, a consultant radiologist and a quality and risk team who regularly reviewed complaints, incidents and risks and produced a monthly newsletter, which was reviewed at local team meetings.
- Governance arrangements were proactively reviewed by the registered manager to ensure best practice was maintained. A systematic approach was taken to work with other external organisations to improve patient care outcomes.
- The service held provider level quarterly clinical governance committee meetings which had structured agenda's, actions and timeframes documented. Examples of items discussed, were incidents, concerns and complaints and areas of learning. In addition to this we reviewed the clinical operations board presentation that was presented in December 2018; this gave a clinical governance overview of the provider and highlighted areas within the company, such as incidents, patient satisfaction and mandatory training for all the provider's sites. All staff had access to this presentation and staff told us that it was a great resource for benchmarking their service.
- The provider had quarterly integrated governance and risk board meeting minutes which had actions and timeframes evident. In addition, there were updates from sub-committees, such as the information and governance committee, radiation protection committee and the health and safety committee.
- The registered manager reported to two radiation protection committees. One for Alliance Medical Limited which was held on a bi-annually basis and one for the host NHS hospital which was held annually but would be moving to bi-annually following the inspection.
- Organisational polices, dual site policies (policies that were shared between the provider and a local NHS trust) and site-specific procedures and processes were in place within the service. We reviewed a sample of policies, such as the risk assessment policy and procedure, the risk management strategy and organisational policy and the quality management framework policy.
- We reviewed a quality audit for referrals received in the period October 2017 to October 2018. The audit looked at referrals accepted, referrals put on hold and referrals rejected. Results demonstrated that improvements were being made monthly. However, actions were highlighted to improve the quality further, such as ensuring that all parties knew that details were required on each section of the form. This audit was presented and shared at multiple meetings around the region to help to reduce the numbers of referrals being rejected and put on hold. We were told by the registered manager that this had been collaborative working with a national body to improve turnarounds times and ensure clear and concise referrals were completed.
- The provider had a central human resources department who managed the recruitment process. Staff files were stored electronically and were not able to be viewed. However, the registered manager had oversight of this process, so she could be assured that all the staff were registered. We reviewed the manager's spreadsheet which showed that all staff had gone through a recruitment process.
- We reviewed the pre-employment checklist within the service, which included disclosure and barring service (DBS) checks, references from the previous three years which had to include the individuals current or most recent employer and copies of professional qualifications where required. All staff documentation was complete and in date at the time of inspection.

- The governance pertaining to image review, discrepancy, turnaround times for reporting and communication of significant findings fell under the jurisdiction of the host NHS trust as per the agreed contractual arrangement.
- On occasions, radiologists did not have access to voice recognition software and used dictaphones when reporting. These were then subsequently typed by administration staff.
- At the time of inspection, the service did not keep a record of the annual quality assurance checks for the diagnostic workstation or internal calibration software. The service told us it understood the calibration of the equipment would be completed by the manufacturer under their existing support contract. Following our inspection, the service told us that the workstation had been serviced and calibrated on the 30 August 2019 and the calibration reports would now be available after every routine service.

Managing risks, issues and performance

- **The service had systems in place 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 maintained their own up-to-date risk register. Each risk had a review date listed as well as actions to mitigate those risks. In addition, there was a named person with responsibility for each risk within the risk register.
- We reviewed a sample of risk assessments in the service, for example isotope production failure: failure in the production process and supply of Fluorodeoxyglucose (FDG) to the Preston PET CT Centre; stress in the workplace, general health and safety and radiation risk for injecting patients for a PET CT Scan. All had risk scores, review dates and actions to mitigate the risks.
- Sealed source documentation and certificates were in hard copies in the manager's office. The folders also contained hard copy contingency plans for easy access when required. In addition to this, we reviewed a live electronic document which displayed where the sealed sources were at any moment in time. Sealed sources are radioactive sources that are permanently sealed in a capsule or bonded in a solid form.
- We saw monthly health and safety checklists. We reviewed the checks that had been carried out in June 2019 which included several items, for example, fire equipment, resuscitation and first aid equipment, electrical equipment and paperwork. All checks were completed, except two checks noted that the control area light dimmer switch was not functioning correctly and the strip lights in rooms two and three were not working properly. Both items had been reported and were awaiting to be resolved.
- We saw that an annual quality and risk audit had been carried out within the service in August 2018 by the Alliance Quality and Risk Assessor to ensure that the delivery of safe services and compliance was indicated for the Care Quality Commission (CQC), Health & Safety Executive (HSE), Quality Standard for Imaging (QSi), Information Governance (IG) and the Environmental Agency (EA) inspections in accordance with the relevant legislation.
- A radiation protection annual audit for the service had been carried out in September 2018 by an external radiation protection advisor to ensure compliance with the necessary Ionising Radiation (Medical Exposure) Regulations (IRMER) and Ionising Radiations Regulations (IRR) legislation. Results demonstrated compliance with standards, regulations and legislation.
- Fluorodeoxyglucose (FDG) had been significantly challenging to the service during the months of November and December 2018. A cyclotron production failure risk assessment was instigated which demonstrated actions on how referrals were prioritised when an FDG failure impacted on access to scans within seven days. We saw evidence of how this worked on the first day of our inspection when FDG was not available. All patients were rescheduled in an appropriate and timely manner.
- There was a business continuity plan that included back-up systems in case of emergencies, such as scan or electrical failures. Back-up generator power was provided by the host NHS hospital.
- If capacity became a challenge to the service, for example a significant period that the scanner was not working; a mobile scanner could be brought to the site to allow an increase in capacity and appointment slots to be made available. We saw this documented in the business continuity plan.
- Electronic organisational dashboards and personal dashboards for staff were used within the service. These were used to support and measure organisational and individual performance.

Good

Diagnostic imaging

Managing information

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- The service through Alliance Medical Limited was accredited as compliant with ISO27001. This is the international standard for assuring Information Security Management Systems; the standard for the safe and secure management of patient identifiable data. This means systems, policies and procedures had been reviewed by an external registered auditor.
- Information governance training was provided to all staff as part of the mandatory training process.
- The service used both paper and electronic information to support its activities. All staff practised in accordance with General Data Protection Regulations (2018). Information governance was part of the mandatory training and all staff were 100% compliant.
- There were systems and processes in place to maintain security of information including patient records and where information was transferred between the service and the host NHS hospital and other referrers, for example for referrals and reports.

Engagement

- **The service engaged with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.**
- The service used patient surveys to collect feedback. We reviewed the feedback and found that all patients were positive about the centre. We did not see any negative comments about staff or the service.
- Public engagement was mainly through interactions with patients and their families when in the centre.
- Staff involved children in the creation of a new patient leaflet. We saw evidence of notes that a paediatric patient had given following their attendance for a scan at the centre. We also saw the old leaflet, the new leaflet and the patient feedback following the production of the leaflet.
- A 'marvellous me' initiative had recently been implemented by the service to boost team morale. A 'cup of kindness' was presented monthly to team members. The registered manager told us that it was important that the team drove this initiative and therefore during a team meeting staff were asked to design a mug that was eventually called the 'Preston CT Mug of The Month'. The cup was filled with items that staff thought the person would like. In April it had been awarded to a staff member for their patience and support during training. The cup was filled with vouchers and tiny gifts that the staff member would like. Every month the cup would be presented by the person who had won it previously; this ensured that it remained a team initiative.
- We saw tables and chairs outside the building for staff when the weather was warm. The registered manager had bought these items for her team so that they could have a quiet area outside to reflect and a nice place to eat together when the weather was warm. There were also flower pots outside that a staff member had grown so that the environment was pleasant and colourful.
- The service had a 'Meet the Team' board which displayed staff names and their roles, images of the scanner, patient comments and what the service had done with the money raised from patients and relative donations from having the complimentary tea and coffee facilities.
- A business wide communication bulletin 'One Team Update' was shared with staff. This bulletin demonstrated how the provider was improving as an imaging provider. Preston PET CT Centre had two examples in the communication letter which demonstrated how locally they had responded to patient feedback. For example, the implementation of a monthly magazine subscription; staff told us that visitors and relatives can often wait up to two hours in the centre. Magazines can help to distract their worries and manage this time. In addition to this, from an infection prevention and control perspective, staff told us that it was better to have quality magazines which were clean and not tatty. The second example was the 'Meet the Team' board. This had been updated and revamped following patient feedback stating that patients did not know who was managing their care.

Learning, continuous improvement and innovation

- **The service was committed to improving services by promoting training, research and innovation.**
- The service promoted continuous learning. Staff we spoke with told us that they were provided with opportunities to attend additional training for their development.

Good

Diagnostic imaging

- Staff we spoke with told us that they could work at other sites which was beneficial in sharing best practice.
- The service was passionate for the development and training of their radiographers and technologists. At the time of inspection, the service was in the process of filming training videos that would sit on a live imaging timeline for patients and staff which, when completed could be used nationally. The learner could pick and choose sections from the imaging timeline from quality assurance, to patient care, image acquisition and image processing. Two staff members assisted in the development of the videos and all staff were used as actors as part of the film production. We saw the videos in their editing stage and they were very informative of the whole PET CT Scanning procedure. This initiative was linked with another NHS trust.
- In addition to the training videos, we saw a patient journey video which had recently been filmed. This was resource that patients could use to follow a PET-CT procedure in advance of their appointment. Staff we spoke with told us that the patient videos would be a great resource for those with a cognitive impairment, particularly where it is important to be able to plan and visualise the situation ahead of their scan.
- The service was involved in research trials. For example, they were participating in a trial for patients with dementia; this was in partnership with an external memory clinic. Ethical and local protocols were all in place for the trial.

Outstanding practice and areas for improvement

Outstanding practice

We found outstanding practice:

- Staff in the service opened the centre in their own time over a weekend to accommodate a paediatric patient that was needle phobic. This allowed the patient to be scanned without having to wait over the weekend with a cannula in place and treatment could commence straight away the following week.
- A bereavement box was in the control room for staff to use in the event that a patient passed away whilst in the centre. Due to the nature of the diseases scanned, patients could be very poorly when they attended. Sadly a few years prior to the inspection, a patient had passed away in the clinic; learning from this had resulted in the service implementing the bereavement box.
- To improve on best practice, the service had recently implemented a second poster specifically aimed for the IR(ME)R operator checklist for administration of radioisotopes for molecular imaging procedures. Staff we spoke with told us this was not only beneficial for staff and patient safety, it was a great resource to have displayed within the clinical areas.
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Areas for improvement

Action the provider SHOULD take to improve

- The provider should consider storing oxygen cylinders off the floor and storing the defibrillators securely and not on a chair.
- The provider should ensure that annual quality assurance checks are performed on the GE diagnostic workstation and the internal calibration software.
- The provider should ensure that cleaning materials are stored in a locked room to comply with the control of substances hazardous to health regulations (200).