Alliance Medical Limited

Newcastle PET-CT Centre

Inspection report

Freeman Road
High Heaton
Newcastle Upon Tyne
NE7 7DN
Tel: 01912137719
www.alliancemedical.co.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Requires Improvement
Are services effective?	Inspected but not rated
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

- Staff provided good care and treatment and gave patients enough to eat and drink. Managers monitored the effectiveness of the service and made sure most staff completed mandatory training and were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' 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 too 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. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving and developing services continually.

However:

- The service provided mandatory safeguarding training but did not make sure everyone completed it.
- Although staff could articulate how they cleaned clinical equipment and the equipment we saw was visibly clean, the service did not keep cleaning records for clinical equipment.
- Some corporate and trust policies and protocols used by the provider were out of date or had incorrect version control. For example, the trust's fire safety management and evacuation procedures, Alliance medical imaging protocols, local rules and corporate consent policy.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	Our rating of this service: we rated it as good. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Newcastle PET-CT Centre

Alliance Medical Newcastle PET-CT service is an independent provider registered with CQC since 2020. It is located within the Freeman NHS hospital and is registered to provide the following regulated activities to the whole population (adults and children):

• Diagnostic and screening procedures

The service has a manager registered with CQC.

The service provided Positron Emission Tomography - Computed Tomography (PET-CT) imaging for NHS and other funded (insured and self-pay) adults and children. PET-CT produces images showing how the cells of your body are functioning. By combining PET and CT in a single scanner, images are produced which can reveal information regarding the exact location, size, nature and extent of disease anywhere in the body with much greater detail.

The service had one static scanner with waiting and recovery areas and separate changing rooms.

Our inspection was unannounced (staff did not know we were coming). This was the first time we had inspected this service.

How we carried out this inspection

During the inspection visit, the inspection team

- inspected all five key questions and rated four; ('effective' key question is not rated for diagnostic imaging services)
- observed four scanning procedures
- looked at the quality of the environment and observed how staff cared for patients
- spoke with the registered manager
- spoke with five other members of staff including allied health professionals, clinical assistants and administrative personnel
- reviewed six patient records
- looked at a range of policies, procedures and other documents relating to the running of the service
- Spoke with two patients

After our inspection visit, we spoke with a further four patients and carers who used the service. We also reviewed performance information about the service and information provided to us by the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

Summary of this inspection

- The service was chosen to participate in a clinical trial for the innovative treatment of Hodgkin's lymphoma. Senior clinical staff at the service wrote the clinical protocol and standard operating procedure to underpin safe practice for the clinical trial.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure all staff have completed mandatory safeguarding training, so they have the necessary skills to recognise and report abuse. Regulation 18 (1) (2) (a).

Action the service SHOULD take to improve:

- The service should ensure appropriate records are kept to evidence clinical equipment has been cleaned and maintained in accordance with manufacturer's guidance.
- The service should ensure all corporate policies and procedures are reviewed in accordance with review dates with correct version control.
- The service should ensure local rules are displayed, show correct document control, and are signed by all staff to acknowledge they have read and understood them.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Requires Improvement	Inspected but not rated	Good	Good	Good	Good
Overall	Requires Improvement	Inspected but not rated	Good	Good	Good	Good

Good

Diagnostic imaging

Safe	Requires Improvement
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Good

Are Diagnostic imaging safe?

Requires Improvement

Mandatory training

The service provided mandatory training in key skills to all staff and made sure most completed it.

Staff accessed the mandatory training policy on the intranet. There was a corporate training matrix which identified the mandatory training modules for all staff groups and the corporate training annual compliance target was 95%.

We inspected training records of 13 staff against the corporate mandatory training needs analysis for permanent staff (TNA). Staff received and mostly kept up-to-date with their mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff. For example, staff completed training on recognising and responding to patients living with dementia. Staff accessed training on-line, with some face to face practical skills sessions.

Training records were uploaded on to an electronic database and compliance was monitored corporately and locally.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it.

The TNA showed safeguarding adults and children was incorporated into induction of new starters and every three years thereafter.

Most staff received training specific for their role on how to recognise and report abuse.

The exceptions were two staff records did not show whether staff had completed or were booked to complete any safeguarding adults or children training. Another had completed adult safeguarding, but no children's safeguarding training was recorded. None of these three staff records showed an induction date. One staff member completed level three safeguarding training in 2018 but had not completed their three-yearly update training. This was not in accordance with corporate policy.

However, all staff we spoke with described the different types of abuse, including female genital mutilation, knew how to make a safeguarding referral and who to inform if they had concerns.

The named corporate safeguarding leads for adults and children and their contact details were identified in the safeguarding policy. Staff we spoke with told us they could also seek advice from the host trust safeguarding team if required.

Cleanliness, infection control and hygiene

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.

Patient waiting and clinical areas were clean and had suitable furnishings which were clean and well-maintained.For example, patient seating was impermeable and could be wiped clean.

Environmental cleaning was completed under service level agreement with the host NHS trust. We saw completed cleaning records in the patient toilet areas.

There were no cleaning records kept for clinical equipment such as the scanner, injection couches, injection trolleys and patient trolleys. However, all equipment we inspected was visibly clean, we observed staff cleaning equipment between each patient interaction and staff we spoke with could tell us how they cleaned specific pieces of equipment. The registered manager explained each appointment slot had five minutes allocated for cleaning.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff complied with arms 'bare arms below the elbows' policy, in accordance with National Institute for Health and Care Excellence (NICE) guidance. We observed staff washed their hands and used hand sanitising gel between patient interactions. This concurred with comments from all the patients we spoke with. We reviewed monthly Infection control and hand hygiene audits, which showed consistently high compliance rates.

We observed public areas had posters which promoted COVID-19 awareness, and hand gel stations.

As part of the referral and booking process, patients were asked infection control screening questions. This meant any infection risks could be managed, for example, patients with a known infection could be added to the end of a list so that appropriate decontamination was completed.

Environment and equipment

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

Access to the department was controlled with key-pad access. The environment was bright and spacious.

All fire extinguisher appliances inspected were serviced within an appropriate timescale. Fire exits and corridors were clear of obstructions. The service used the trust's fire safety management and evacuation procedures. However, we noted the document was due review in May 2020. Fire alarms were tested weekly. The service carried out unannounced annual fire drills which included a full evacuation.

Good

Diagnostic imaging

Access to clinical areas was strictly controlled with key- pad locks and appropriate radiation warning signage. Staff wore dosimetry badges which uploaded radiation exposure data to a computer and was monitored by the corporate occupational health service.

The design of the environment followed national guidance. For example, there was a dedicated 'hot room' where radioactive isotopes were drawn up prior to administration, dedicated patient change rooms, three uptake rooms where patients were cannulated and administered radioactive tracer and a separate 'hot toilet' reserved for patients who were considered radioactive themselves. There were emergency call bells in all patient areas.

There was a recovery area with disposable curtains that were dated when changed.

The control room had three monitors and a large viewing window to ensure staff could always see patients in the scanner.

Staff carried out daily safety checks of specialist equipment. For example, the emergency resuscitation equipment trolley was checked Monday to Friday when the service was open, although there were apparent gaps at weekends, and we were told the service was occasionally operational on Saturdays by prior arrangement. We brought this to the attention of the registered manager at the time, who told us they would ensure subsequent records would show when the service was closed.

Scanner daily and weekly checks were recorded on a spread sheet and dated with no missing entries. Staff we spoke with explained the daily checks including calibration and weekly checks using phantoms and recommended manufacturer guidelines. A phantom is a specially designed object that is scanned to evaluate, analyse, and tune the performance of the scanner.

The service had enough suitable equipment to help them to safely care for patients. For example, there was a gantry installed to allow hoisting of patients and the scanner table was suitable for most bariatric patients.

There were systems for recording the service and planned preventive maintenance of equipment, identified through a central log and equipment compliance stickers, which indicated the dates tests were due. An external provided conducted planned preventive maintenance for the PET-CT scanner and medical equipment in accordance with a schedule.

Most equipment we inspected was serviced and fit for use. The exception was a monitor with a battery pack which had failed its test. We brought this to the attention of the registered manager at the time and a replacement battery pack was sourced.

The radioisotopes were delivered on order and were checked, handled and stored in accordance with national guidelines. Staff knew how to dispose of unused material and kept a record of receipt from the supplier. There was a spillage kit available and staff we spoke with knew how to use it.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Services were delivered to the whole population.

Good

Diagnostic imaging

Referral information was reviewed prior to booking to identify individual patient risks. Staff also completed risk assessments (safety questionnaires) for each patient on arrival, to ensure patient safety and that the facility was suitable for them.

Staff knew about and dealt with any specific risk issues. For example, pregnant women and breastfeeding status. Staff we spoke with were aware of the signs and symptoms of sepsis.

Staff accessed the corporate critical, urgent and significant pathology local standard operating procedure on the intranet. This described the escalation process for adverse and incidental findings that required medical attention.

Staff responded promptly to any sudden deterioration in a patient's health. The service ensured there was a member of staff trained in immediate life support (ILS) on duty every day and a paediatric life support trained staff member, when children were scanned. There was also a service level agreement in place with the host trust, for their emergency response team to attend in the event of an emergency call.

There were formal imaging protocols in place for all types of scan undertaken at the service, in accordance with Administration of Radioactive Substances Advisory Committee (ARSAC) guidance. We noted this document was version 1.0 and for review in March 2022. However, the document footer showed version number 1.4 with a review due date of October 2022 on the document. This meant we were unclear about the document control.

Staff accessed local IRMER rules and a suite of associated local procedures on the intranet. These were reviewed annually. However, the hard copy local rules we were shown in a file were dated March 2020 and had no review date. Two staff had not signed the local rules to indicate they had read and understood them. All staff we spoke with were aware of written rules but there were none displayed in the scanning room to highlight designated areas and details of the Radiation Protection Advisor.

The service had access to a named radiation protection advisor (RPA) who advised on complying with the Ionising Radiations Regulations 2017 and two named medical physics advisors. These were experts in radiation physics and technology.

Radiation doses were recorded on the patient record held on the electronic radiology information system (RIS).

The service did not carry out sedation. This was at the request of the trust hospital and they always provided a suitable trained escort (usually a paediatric nurse) for children during the procedure.

Specified radioactive substances were administered by named practitioners under licence issued by the Secretary of State.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service was led by a specialist clinical lead. The service had enough staff to keep patients safe and the number of staff matched the planned numbers. There were always three staff on duty.

The service had no vacant posts.

Good

Diagnostic imaging

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient records were held on the secure RIS system and all staff could access them easily.

We inspected six records. All referral documentation was completed correctly, and we saw comprehensive clinical details recorded. All consent forms were inspected were completed correctly and contraindications were checked.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff accessed the corporate medicines quality policy and procedure on the intranet.

Except for cylinder oxygen and emergency medicines stored on the emergency equipment trolley, there were no medicines stored at the service.

Emergency medicines were all within expiry dates and stored in a sealed box.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. 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.

There was a corporate incident management framework which staff accessed on the intranet. Staff we spoke with knew what incidents to report and how to report them on the electronic risk management system.They gave specific examples of incidents and near misses they had reported, in line with the service's policy.

Managers shared learning with their staff about serious incidents such as unintended exposure to radiation that happened elsewhere.For example, in the safety bulletin and in shared clinical governance meeting minutes.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers received patient safety alerts from the corporate governance team and any actions taken by the service were recorded on a corporate electronic log.

Good

Diagnostic imaging

Are Diagnostic imaging effective?

Inspected but not rated

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. For example, we saw policy documents contained links to National Institute for Health and Care Excellence (NICE) guidance.

Compliance against policy was monitored throughout the year using a corporate audit schedule. Audits were completed on an electronic platform.

Staff we spoke with explained how they accessed the most current best practice guidance online and intranet, for example NICE guidance and up to date COVID-19 guidance.

Nutrition and hydration

Staff made sure patients were not without food for long periods.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. For example, patients who attended from out of area and patients living with diabetes were advised to bring their own packed lunch, but light refreshments and fresh drinking water were freely available in the waiting area, for patients and those accompanying them.

Pre-scan fasting and any dietary instructions were clearly explained verbally by the bookings staff, in written leaflets which accompanied appointment letters and on the service's website. Patients were requested to be nil by mouth for six hours prior to appointment but could sip water if thirsty. They were encouraged to drink plenty of fluids after the scan to help flush out any unabsorbed tracer liquid.

Pain relief

Staff monitored patients regularly to see if they were in pain.

The service did not prescribe or administer pain relief medicines. However, unless told otherwise, patients could continue to take any prescribed and over the counter medicines, including their own pain relief.

We observed staff ensured patients were comfortable while they waited for the isotope injection to be absorbed and patients were positioned comfortably in the scanner to minimise pain and discomfort.

Staff observed patients while they were in the scanner and patients could communicate via a two- way microphone if they had any concerns during the procedure.

Good

Diagnostic imaging

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. For example, April 2021 audit data we reviewed for administered activity against Ionising Radiation (Medical Exposures) Regulations 2017, Schedule 2(f) indicated 100% compliance.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Local audits included, for example, compliance with imaging referral guidelines. 10% of referrals every month were audited. Results we saw for October 2021 showed 80% compliance against a target of 100%.

Audits of dose reference levels were displayed for both adult and paediatric patients. National dose reference levels were available in the radiation protection supervisor's folder and on comparison, the local dose levels were lower than the national benchmark.

Image quality was consistently good, and staff were competent to scan all examinations. A trust consultant radiologist we spoke with in the department told us the scans were of sufficient quality to produce a definitive report, and in accordance with scans produced at the trust.

The service was accredited by UKAS quality standard for imaging (QSI).

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff revalidation records were held corporately.

The staff frequently used radiotracers. The ARSAC licensed radiologist showed us an authority document during inspection which permitted the staff, through him, to use these tracers and a new specific test tracer (Zirconium 89), being used to test and treat patients with lymphoma.

Managers gave all new staff a full induction tailored to their role before they started work. There was a corporate induction policy and associated checklist which underpinned the process.

Managers supported staff to develop through six-monthly, constructive appraisals of their work.

A corporate system supported the learning and development needs of staff. Supervision was provided by the clinical lead.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Good

Diagnostic imaging

Managers made sure staff received any specialist training for their role.

Multidisciplinary working

Healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Patients could see all the health professionals involved in their care identified on a photo board in the waiting area.

Staff supported each other to provide good care and flexed their working hours to accommodate the needs of patients.

Seven-day services

Key services were available to support timely patient care.

The service was operational Monday to Friday 8am to 8pm and occasionally on Saturday mornings, by prior arrangement.

There was comprehensive information available for referrers and patients on the service's web site and in leaflets at the service.

Patients who required extra support were identified at the referral and booking stage.

Staff could call for support from the trust. For example, the service had a formal agreement in place with trust radiologists. They liaised with staff regularly and they had easy access to advice through email, and mobile phone. The radiologists were always contactable to escalate an urgent scan and to report immediately if required.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in patient areas and information could be downloaded from the service's web site. For example, COVID-19 awareness, pregnancy safety posters, radiation awareness and specific pre-scan dietary advice for cardiac and diabetic patients.

Patients we spoke with were clear about radiation safety and were recommended not to have close contact with pregnant women or young children for eight hours after their scan.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff accessed the corporate consent policy on the intranet. This contained links to Department of Health guidance. However, we noted the policy this was due review in May 2021.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. For example, capacity was included in referral information and staff received dementia awareness training.

Good

Diagnostic imaging

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Staff clearly recorded consent on consent forms.

Staff understood Gillick Competence and supported children who wished to make decisions about their treatment. For example, when they completed the safety questionnaire/PET-CT patient data form and exclusion of pregnancy form.

Are Diagnostic imaging caring?

Good

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. We observed how staff took time to interact with patients and those close to them in a respectful and considerate way. The staff explained the expected waiting time and process for receiving for results.

All patients and relatives we spoke with told us they were very satisfied with care received and the way the staff treated them with dignity, respect and kindness.For example, they told us they were ‘’really impressed’’, ‘’staff were really nice’’ and ‘’they were quick and efficient’’. This concurred with the friends and family feedback we reviewed which showed consistently high satisfaction scores. We saw several positive comments from patients in the patient feedback the service provided.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support when they needed it. For example, there was a facility for patients to have calming music playing while they waited in the uptake room.

Administrative staff we spoke with were often the first point of contact with patients when booking appointments and they were mindful that some patients felt anxious and distressed. We heard them speaking to patients in a supportive manner to minimise their anxiety.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.For example, some patients told us they returned for repeat scans and described the positive, supportive relationship the staff had built with them over time.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Good

Diagnostic imaging

Staff talked with patients, families and carers in a way they could understand. For example, at the time of booking, patients were asked questions regarding disabilities and information was available in braille by request.

Staff involved patients in decisions about their care and treatment. Patients we spoke with told us they felt fully informed about their treatment plans and arrangements for results.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.For example, via an on-line patient satisfaction survey form and comments on social media platforms.

Patients gave positive feedback about the service. All patients and carers we spoke with told us they were very satisfied, and this concurred with the latest friends and family feedback results, which indicated 100% of respondents were likely to recommend the service to others. Feedback was reviewed locally and corporately.

Are Diagnostic imaging responsive?

Good

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population.

The registered manager worked hard to promote a positive working relationship with other health providers in the area. For example, scanning services were available for NHS patients where commissioners had identified capacity shortfalls or for patients who wished to exercise their rights of flexibility and choice, under the e-referral system (previously known as choose and book) or wished to self-pay.

Facilities and premises were appropriate for the services being delivered.

The service had systems to help care for patients in need of additional support or specialist intervention.

The service was located within a host NHS trust and there was ample car parking.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The service provided services for mostly NHS patients but also saw private-insured and self-funded patients. Where possible, appointment times were booked at a time suitable to patients and carers.

Staff supported patients living with conditions such as claustrophobia, dementia and learning disabilities. For example, patients could attend a pre-scan visit or could have light sedative prescribed by their GP prior to attending, to help them feel calmer.

Good

Diagnostic imaging

The service was accessible for patients with limited mobility and people who used a wheelchair.

The service had information leaflets available in languages spoken by the patients and local community. They were also available in braille.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times for treatment were in line with national standards.

Access to services was by medical referral only. Patients were referred by GP's under the 'any qualified provider' system (AQP), which is a type of NHS contract, which allows non- NHS as well as NHS organisations to provide NHS services.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

Managers worked to keep the number of cancelled appointments to a minimum. For example, data we reviewed for the period October 2021 to March 2022 showed of 2926 appointments, 2203 scans were completed and 723 were not completed. Cancelled appointments were due to patient's not arriving for appointments, cancellations by the provider due to isotope failure or capacity issues and abandoned scans.

The registered manager explained cancelled scans were mostly due to isotope failure and regional data we reviewed for March 2022 showed that the service had 50 isotope failures in the last quarter year.

Radioactive isotopes are injected into a vein and used as a tracer to optimise image quality. They have a short life and must be used within hours. They were manufactured at specialist sites and transported to the service. However, we noted isotope failures were largely due to supply and transportation disruptions, and this was not within the control of the service.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. For example, patients were sent to an alternative facility by taxi, at no expense to the patient, to ensure they received their scan and to minimise report turn-around time.

All patients we spoke with told us they had received their appointments very quickly and were not kept waiting too long in the department.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service clearly displayed information about how to raise a concern, in patient areas.In addition, there was information on the host trust website signposting patients to the patient advice and liaison service (PALS) if they wished to raise a concern about the PET-CT service.

Staff understood the policy on complaints and knew how to handle them.

Good

Diagnostic imaging

The service had not received any formal complaints however, managers shared all feedback from patients with staff and learning was used to improve the service. For example, the service brought music into the uptake rooms and installed music players in each room, to reduce patient anxieties while they were waiting.

Are Diagnostic imaging well-led?

Good

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The provider met the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors are fit and proper to carry out this important role.

A photo board which showed staff and their roles was displayed in the reception area. The service was led by the registered manager and specialist clinical lead. They received support from the Alliance Medical Limited regional manager and corporate team. The senior leaders had extensive healthcare management and clinical leadership experience.

All staff we spoke with considered the leaders to be visible. For example, they facilitated team meetings, regularly walked round the service and spoke with patients and staff.

Staff we spoke with told us how managers supported them to develop their careers, with a view to succession planning.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a formal vision and strategy in place aligned to corporate vision of innovation, integration, sustainability and standards, and the overriding value that patients are put first.

The registered manager attended regional service review meetings where the service monitored progress against the vision and strategy and corporate objectives. For example, finance, performance and patient experience were discussed.

The registered manager we spoke with described their plans for the service. For example, to extend the department to accommodate a second scanner.

Good

Diagnostic imaging

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

All staff we spoke with said they enjoyed coming to work and felt they had good relationships and worked well as a team.

Policies we inspected all had equality impact assessments. Staff mandatory training included equality and diversity training. There was a stress management policy in place which supported staff and promoted a healthy, safe and caring environment.

The corporate human resources director was appointed as the freedom to speak up guardian, supported by freedom to speak up champions.

Staff we spoke with described an open culture and told us they felt their opinions mattered to managers. They were aware of the freedom to speak up policy and said they were confident to raise any concern with their managers.

Patients we spoke with told us they felt confident and comfortable to raise any concerns with staff.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a corporate policy for safer recruitment and a corporate clinical governance policy.

There was a national clinical advisory committee (CAC) which met every three months. The agenda included audit, governance, shared learning from incidents, and policy updates.

In addition, there was a formal clinical governance meeting held every two months. The agenda included IPC, escalated events (incidents), performance data, patient experience, and research updates. Updates were also provided by sub-committees such as CAC, medicines quality, research and IPC committees.

The risk register was reviewed, and policies approved and ratified at the meeting.

The service had formal regional service review meetings every four months to discuss performance, patient satisfaction and shared learning.

We saw evidence staff at the service were given feedback about incidents and lessons learned from, comments, compliments and complaints via a bulletin and verbally at team meetings.

The provider was a member of the Independent Sector Complaints Adjudication Service (ISCAS), a nationally recognised organisation in the management of complaints in the independent health sector and followed their code of conduct.

Good

Diagnostic imaging

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had an electronic risk register, which was reviewed every two months at the regional clinical governance committee meeting. This fed into the corporate risk register, which identified key risks at a national, regional, and local level.

The risk register was treated as a live document and updated throughout the year as required in addition to a formal review six- monthly at the corporate integrated governance and risk board.

We saw the service had a comprehensive business continuity plan in place with clear action cards for managers to refer to. The registered manager explained that should the scanner fail, the contingency was to divert patients to another Alliance Medical PET-CT facility.

There was a full audit plan for the year. These audit plans were in line with the wider group requirements. Audit results were presented to staff at departmental meetings.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Important information such as policies and minutes of meetings were accessible to all staff.

Health records, referrals and diagnostic results were held on the secure electronic RIS system. The appointment booking system was electronic.

Records were submitted corporately to the Diagnostic Imaging Dataset (DID) during 2020-2021. DID is a database that holds information on the imaging tests and scans carried out on NHS patients. This allowed the Health and Social Care Information Centre to see how different tests were used across the country.

Staff completed mandatory information governance and General Data Protection Regulation (GDPR) training.

Alliance Medical Ltd continued to comply with ISO 27001:2013 and was re-certified in October 2020. Certification was in place until October 2023.

Alliance Medical Ltd completed an annual self- assessment in June 2021 for the 2020/21 NHS Digital Data Security and Protection Toolkit and the assessment showed standards were met.

Alliance Medical Ltd were also reaccredited with Cyber Essentials in October 2020.

Good

Diagnostic imaging

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service engaged well with patients, staff, the public and NHS trusts to plan and manage appropriate service and collaborated with partner organisations effectively. It developed services with participation of staff and patients and demonstrated commitment to acting on feedback.

The service's website provided a wide range of information about the referral process and clinical services available.

Managers were visible, which provided patients and visitors with opportunity to express their views and opinions face to face.

Staff we spoke with told us managers engaged with them, were very supportive and visible. Staff said they were encouraged to voice their opinions and speak with managers if they had any concerns. They told us they felt appreciated by their clinical colleagues and service managers.

Employee engagement across all Alliance Medical Ltd sites was measured through a two- yearly employee survey which was conducted by an independent organisation. The most recent 'experience at work' staff survey results for staff experience and perceptions showed improvements compared with the 2019 survey and were positive.

Staff feedback was also collected via a 'response to the pandemic' survey and leaver questionnaires.

There was a corporate staff recognition scheme #Alliance Heroes which was launched in spring 2020, and a well-being programme which included an external employee assistance programme.

We saw the staff were nominated recently in the trust's Greatix excellence reports for 'putting the patient first'. This nomination recognised the team's rapid response to prioritise a scan for a very unwell patient and their excellent communication with the patient's inpatient team throughout.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff we spoke with said they were supported to attend internal and external training, to develop their career.

Staff we spoke with told us about an ongoing clinical trial the service was involved in, to treat non-Hodgkin's lymphoma. The scan was designed to treat as well as used as a diagnostic check. Staff explained a radioactive isotope was used which mimicked the action of a drug used to treat the condition. Senior clinical staff at the service produced the clinical protocol and standard operating procedure. We were told initial results were positive and staff said they felt proud to be chosen to be part of this new initiative.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The service did not ensure all staff completed mandatory safeguarding training, so they have the necessary skills to recognise and report abuse. Regulation 18 (1) (2) (a).