Alliance Medical Limited

Taunton PET CT

Inspection report

Musgrove Park Hospital
Parkfield Drive
Taunton
TA1 5DA
Tel: 08450450103
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	Requires Improvement
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?	Requires Improvement

Summary of findings

Overall summary

This service had not been previously inspected. We rated it as requires improvement because:

- The service provided mandatory training in key skills to all staff and but not all staff completed it. Some training was considered optional but should have been mandatory. Lessons learned from safety incidents were not always disseminated to staff effectively. Not all staff were up to date with training associated with the administration of radiopharmaceuticals.
- Governance processes were not always effective. Documentation allowing nuclear medicine practitioners to inject, and order radiopharmaceuticals did not reflect up-to-date licence numbers. There was no evidence current risks recorded on the risk register were reviewed and updated in line with company policy.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in most 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 care records. They managed medicines well. Staff knew how to report patient safety incidents.
- Staff provided good care and treatment, gave patients enough to eat and drink. Managers monitored the effectiveness of the service. Staff worked well together for the benefit of patients. Scanning services were available seven days a week.
- 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 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 service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Staff at all levels were clear about their roles and accountabilities and had opportunities to meet, discuss and learn from the performance of the service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Requires Improvement 	This service has not been previously inspected. We rated it as requires improvement. See the summary above for details

Summary of findings

Contents

Summary of this inspection

Background to Taunton PET CT

Taunton PET-CT centre is based at Musgrove Park Hospital and is owned and operated by Alliance Medical Limited. This service performs PET (Positron Emission Tomography) and CT (Computed Tomography) scans for NHS patients from most NHS Trusts in the geographical area. This offers patient choice for scanning.

PET-CT imaging is a type of molecular imaging which provides valuable information about the structure or anatomy of the tissues being examined. By giving small quantities of a radioactive injection, PET produces images showing how the cells of the body are functioning. By combining PET and CT in single scanner, images are produced which reveal information regarding the exact location, size, nature and extent of disease anywhere in the body in greater detail.

The service operates from 7.45am to 7.45pm Monday to Friday with additional CT scans performed over the weekend depending on demand. From 1 April 2021 to 30 September 2021, the service carried out 2699 examinations on 2001 patients. In the same timeframe, 30 patients did not attend their appointment.

The service is provided as part of a national contract issued and overseen by NHS England and Improvement.

The service is registered for the regulated activity of diagnostic and screening procedures.

This service was registered in 2017 and has an interim registered manager in post since October 2021.

How we carried out this inspection

The team that inspected this location comprised of two CQC inspectors and a specialist advisor with expertise in diagnostic radiography including nuclear medicine. We spoke with five members of staff including the interim registered manager, two patients on site, held telephone interviews with three patients and observed interactions with patients throughout the day. We reviewed documents and records kept by the provider and inspected the scanning department.

There were no special reviews or investigations of the location ongoing by the CQC at any time during the 12 months before this inspection.

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:

- Following their scan, staff gave all patients a card with details of how the patient would get their result and who had asked for the scan.
- Staff used a physical barrier to remind themselves and other patients not to enter the scan room unnecessarily and minimise the risk of anyone entering the room during the patient's scan.

Summary of this inspection

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:

- Persons providing care or treatment to service users must have the qualifications, competence, skills and experience to do so safely. This includes dementia awareness training, Mental Capacity Act, Deprivation of Liberty and Ionising Radiation (Medical Exposure) Regulations (IM(ER)R) 2017 as mandatory training subjects. Regulation 12 (2) (c)
- The service must ensure care and treatment is provided in a safe way for service users doing all that is reasonably practicable to mitigate any risks including sharing learning from incidents. Regulation 12 (1) (2) (b)
- Systems and processes must be established and operated effectively to ensure compliance with regulations and adhere to the provider's own policy regarding quality assurance. Regulation 17 (1)
- The provider should assess, monitor and improve the quality and safety of the services provided. This includes an up-to-date risk register more reflective of the risks faced in the carrying on of the regulated activity. Regulation 17 (2) (a)
- Governance arrangements for oversight of staff training must be more accurate and effective. Regulation 17 (2) (d) and (i)
- Pause and check guidance must be performed for every patient before administering injections or scanning the patient. Regulation 12 (1) (2) b

Action the service SHOULD take to improve:

- The training matrix should record the level of safeguarding training completed by staff.
- Consider making information more readily available in other formats such as easy read, braille or in different languages.
- The manager should review the need for regular team meetings for staff to discuss issues arising, learning from incidents and complaints.
- Review and update documentation giving nuclear medicine practitioners authority to order and inject radiopharmaceuticals to reflect current licence numbers.
- Make sure staff are up to date with any training associated with the administration of radiopharmaceuticals.
- Review and update all current and future risks in line with company policy.
- Should ensure training is undertaken as required for the spillage procedure as prescribed in the policy.

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	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Inspected but not rated	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Diagnostic imaging

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

Are Diagnostic imaging safe?

Requires Improvement

We have not rated safe before. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to staff and but not all staff completed it.

Staff received and usually kept up to date with their mandatory training. Staff regularly undertook mandatory e-learning which continued without interruption during the pandemic. Where face to face training was required, such as immediate life support, sessions had been arranged with staff.

The unit had a training matrix which showed 100% staff compliance against 15 mandatory training subjects except immediate life support, which was 20%. This did not match the training needs analysis provided which showed the service had 28 mandatory training subjects. We noted three staff had recently completed the training (not reflected on the matrix), two were on sick leave and one member of staff was booked onto the training. As the unit had eight substantive employees, the low rate of compliance could be interpreted as skewed data.

There was evidence staff working with radiation had appropriate training in the regulations, radiation risks, and the use of radiation. However, we saw from training records, modules covering Ionising Radiation (Medical Exposures) Regulations (IR(ME)R) 2017 updates were listed as optional rather than mandatory as was required by IR(ME)R. We found two staff had undertaken this training and one had yet to compete the training which was part of their ongoing induction and probation period. However, the matrix stated 100% compliance. The interim registered manager told us this had been raised with the head office who had central oversight of all training compliance.

Training compliance was monitored centrally. Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us when they had asked for additional or specialist training, the service supported them to attend.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Staff maintained up-to-date mandatory e-learning which included Safeguarding Vulnerable Adults, Safeguarding Adults at Risk and Safeguarding Children modules. Training compliance was 100%, although the level of training completed was not documented on the unit training matrix.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were aware of the corporate Safeguarding Adults and Safeguarding Children Policies and referred to them if they had any safeguarding concerns. Safeguarding Leads' contacts for the adjoining NHS trust and the provider were displayed in the unit.

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.

Clinical areas were visibly clean and had suitable furnishings which were also clean and well maintained. Cleaning staff accessed the department out of hours due to radioactive materials stored on site, this was restricted to general areas only.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw equipment cleaning was incorporated into daily cleaning checklists. In all clinical areas we saw specialist cleaning wipes and saw staff using them to clean equipment between each patient scan.

Areas where radioactive materials were kept, such as the injection preparation room and the waste storage cupboards, were cleaned by clinical staff. All restricted areas including waste storage areas were visibly clean and uncluttered.

Staff followed infection prevention and control principles including the use of personal protective equipment (PPE). The provider had a central PPE hub based at head office and an electronic based reporting and ordering system to provide an effective and efficient stock of PPE and cleaning materials. Each week, the unit manager or clinical lead submitted a tailored request for stock depending on the unit's needs and delivery was received every Wednesday. An email address had been set up for any urgent PPE needs or feedback regarding the stock.

Precautions were taken when seeing people with suspected communicable diseases such as influenza. Where a patient was known or suspected as having a communicable disease, they were given an appointment at the end of the scanning list to enable deep cleaning after their scan.

The service used infection control measures when carrying out a consultation or performing a scan which included the use of face masks, aprons and gloves. The unit had been classed as safe and secure following completion of a COVID-19 secure risk assessment, which was reviewed quarterly. The unit carried out a monthly infection prevention and control audit and the latest monthly hand hygiene audit showed 100% compliance.

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 waste well.

The design of the environment followed national guidance. The design of a Positron Emission Tomography and Computed Tomography (PET-CT) unit took account of the doses of radiation administered to patients. As such,

individual cubicles were required for each patient to lie in after their injection. Staff had enough space to move freely through the department, but also able to maintain safe distances from radioactive materials and patients after they had received their injection. Patients who had received their radioactive injection had their own separate toilet to use to prevent contamination for staff and other patients.

Each patient cubicle had a call bell and staff explained how they responded to these but maintained a safe distance from the patient. The scan room was constantly observed during scanning.

Staff carried out daily safety checks of specialist equipment. The PET-CT scanner underwent daily quality assurance checks and staff could describe what they would do if any of the checks fell outside of acceptable ranges. Other specialist equipment such as Geiger counters and the assay calibration device, were checked daily and serviced annually.

Staff disposed of clinical waste safely. Staff showed us how they monitored and stored clinical waste bags which contained radioactive waste. Staff explained radioactive clinical waste had to be stored until the level of radiation had decayed to a safe level. The waste could then be disposed of in the same way as normal clinical waste. Due to the short half-life of the radiopharmaceuticals used, staff explained they did not need to store the bags for very long, which meant the waste did not build up in the storage cupboard.

Resuscitation equipment was readily available, the trolley was adequately stocked and there was evidence of regular reviews. We checked the contents of the resuscitation trolley and found everything listed was present and in date.

The imaging service had completed risk assessments for all new or modified uses of radiation, which were reviewed annually or whenever a change occurred. This was last undertaken in October 2021. If there were any changes, for example, a new protocol; the risk assessment would be re-reviewed.

Risk assessments addressed occupational safety as well as considering risks to people who used services and the public. For example, doses of radiation to members of the public and to patient escorts, such as nursing staff.

The service ensured controlled areas (where ionising radiation was present) were restricted to authorised personnel only. Doors to the unit were locked with key code pads to prevent unauthorised admittance.

Ionising radiation was used as part of the CT element of the scan, so ionising radiation warning lights were not on during the PET scan. There was clear signage when ionising radiation exposure occurred. For this reason, staff had implemented the use of a physical barrier to prevent people from accidentally entering the scan room during a PET scan.

The service ensured specialised personal protective equipment was available and used by staff and carers when needed. Staff showed us the syringe shields, lead screens and storage facilities for the radiopharmaceuticals and we saw staff use them to dispense and administer injections safely to patients.

The provider undertook assessments and reviews of their activities under the Control of Substances Hazardous to Health Regulations 2002.

The service had an equipment Quality Assurance programme for all equipment and had input from a medical physics expert. Equipment was operated and maintained consistent with the manufacturer's recommendations. We saw a planned preventative maintenance schedule for both PET and CT elements of the scanner.

Requires Improvement

Diagnostic imaging

There were service contracts for equipment and a clear process for maintenance of equipment and for reporting of any faults. As part of each service, handover documents were done for the engineer prior to service and again from the engineer after service. Documents contained details of known issues and repairs plus a general report on the performance of the equipment.

The service managed aging equipment and equipment failures through a rolling capital replacement programme, which was overseen centrally at the provider headquarters. The scanner was four years old, so was not due for replacement.

The service monitored staff for radiation exposure using dosimeters. Staff wore one on their torso and a finger-based dosimeter when handling, drawing up and administering radioisotopes. Dose reports were reviewed by the registered manager on a monthly basis, and any high or outlying doses were discussed with staff. For example, if a member of staff had a high finger dose, they were offered additional support, observation and training in handling radioisotopes.

The service had a dedicated spillage kit in the case of a radioisotope spillage or significant blood spillage after administration of the radioisotope to a patient. The registered manager had provided some scenario-based training around droplet spread and spillage containment. Training records showed this had last been done in 2019. We requested the spillage policy to understand how often training should be undertaken but this was not provided. Staff told us they knew where the spillage kit was located and how to use it.

The service had an Environment Agency inspection on 12 October 2021. Several minor recommendations had been made but no breaches found.

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

Staff responded promptly to any sudden deterioration in a patient's health. There were clear pathways and processes for the management of people who were, or became, clinically unwell. As part of the contract with the hosting NHS trust, staff followed the same emergency call process as the rest of the trust by calling 2222 for help.

There were processes to ensure the right person got the right scan, at the right time. Staff printed out all referrals in advance of patients attending and called the IR(ME)R practitioner licence holder (formerly Administration of Radioactive Substances Advisory Committee licence holder) or referrer if there were any queries or discrepancies on the referrals. Staff told us they knew the licence holders well, spoke to them regularly and they were readily available for advice.

The service followed the Royal College of Radiologists' Standards for the communication of radiological reports and fail-safe alert notifications. As part of the National PET-CT Contract with NHS England, the service was committed to undertaking scans and processing reports within seven days. Images were uploaded to the Alliance Medical electronic system centrally which was accessed by the IR(ME)R licence holder or another approved reporter. Final, verified reports were automatically transferred (along with images) to the Trust PACS system on publication of the report.

Staff followed the Society of Radiographers "pause and check" guidance when checking patients' identity before administering injections or scanning the patient. This was documented by signing a form and scanning it into the booking system. The service audited compliance with identity checks and the latest audit for September 2021 showed two patients out of 57 did not have their identity checked.

Requires Improvement

Diagnostic imaging

The imaging service ensured the radiation protection advisor and the medical physics expert were easily accessible for providing radiation advice, even though they were based remotely in Birmingham. Staff explained the radiation protection advisor and medical physics expert were available for escalation of incidents and advice as well as attending radiation protection committee meetings on behalf of the service.

The service appointed radiation protection supervisors in departments which used ionising radiation. A recent change in staffing meant one of the senior nuclear medicine practitioners had been promoted to clinical lead which also encompassed the role of radiation protection supervisor. Staff told us they had attended specialist training to undertake the radiation protection supervisor role and felt supported by senior management.

The service ensured the 'requesting' of a PET-CT scan was only made by staff or persons in accordance with IR(ME)R. The service held a list of approved referrers and any requests received from persons not on the list were immediately escalated by the IR(ME)R practitioner licence holder for clarification.

The service adopted a referral criterion which meant they did not scan anyone under the age of 18.

The service ensured ensure staff were aware of women who were or may be pregnant before they were exposed to any radiation in accordance with IR(ME)R and for staff in accordance with Ionising Radiation Regulations (IRR) 2017. We saw posters displayed in patient areas telling them to speak to a nuclear medicine practitioner before they were scanned. Staff also showed us they could perform basic pregnancy tests for patients if necessary. Pregnancy status was recorded and scanned into the electronic patient record system.

Patients were given information explaining how appointments were managed to minimise risks during the COVID-19 pandemic. We saw this on appointment confirmations and reminders.

Staff who performed CT scans at weekends had access to patient's kidney function tests, which were required before injecting contrast for the scan. This was in line with National Institute for Health and Care Excellence (NICE) Acute kidney injury guidelines (NG 148, 2019) and the Royal College of Radiologists standards for intravascular contrast agent administration (2015).

When the provider received a referral for a patient with a suspected allergy to contrast, they asked for advice from the on-call radiologist. In most cases, a non-contrast scan was performed.

There were clear processes to escalate unexpected or significant findings both at the examination and upon reporting. Images and reports were turned around within a seven-day window, so reports from scans were readily available to referrers.

The service had a set of local rules and employer's procedures available to protect staff and patients from ionising radiation. We checked these documents and saw they had recently been reviewed and signed off.

Staffing

The service usually 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. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough nuclear medicine and support staff to keep patients safe. The service had a radiographer, two PET-CT technologists, two administrator/clinical assistants, a unit manager and one administrator. The manager

accurately calculated and reviewed the number of radiographers, technicians and support workers needed for each shift. The number of staff matched the planned numbers. Managers made sure bank and agency staff had a full induction and understood the service. Alliance Medical Limited supplied bank staff wherever possible to meet demand. The benefit of this was staff were already familiar with the way of working safely and effectively.

Health Education England identified shortages in the provision of clinical and diagnostic radiographers for cancer services. The provider ensured adequate staffing through a rolling recruitment programme from head office.

The service always had a medical consultant on call during evenings and weekends. Staff could contact a radiologist or IR(ME)R practitioner licence holder for advice. When contrast was administered, the provider had access to a suitably trained clinician seven days a week. As the centre was in the grounds of an NHS trust, radiologists (as part of a service level agreement) were on call for advice at weekends.

Records

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

Patient notes were comprehensive, and all staff could access them easily. There were no delays in staff accessing their records. Records were stored securely.

The service ensured imaging requests were appropriate and included the relevant information to allow for requests to be justified in accordance with IR(ME)R. The practitioner licence holder was responsible for vetting and approving requests from a pre-approved list of referrers. Any queries or issues were followed up by the licence holder prior to being passed to the service for appointment. Staff then further checked the referral information and raised queries with the licence holder when needed.

As part of the justification process to carry out exposure to radiation, the imaging service attempted to make use of previous images of the same persons requiring the test. The service stored images on a wider picture archive communication system, which meant they could access previous images if the patient had been scanned at any of the Alliance Medical sites. The registered manager explained they could not yet access the NHS trust's picture archive communication system which meant they did not always have access to all the patients' scans and reports when the patient attended for their scan. However, all previous images were made available to the radiologist who reported the scan.

Where appropriate, patient information was transported with patients when they attended for a scan. Staff explained referrals were first accepted onto the NHS trust's referral system for vetting then passed to the service to be uploaded onto its electronic booking system. This meant inpatients (from the adjoining NHS trust) always had their notes with them which included any treatment escalation plans or 'do not attempt cardio-pulmonary resuscitation' documentation.

Staff told us there were two picture archive communication systems to store images. Once the patient had their scan, all images were uploaded centrally to the Alliance Medical picture archive communication system and redirected from headquarters back to the practitioner license holder for reporting. There was a dedicated team centrally who oversaw and checked all images were sent within the seven-day target under the NHS England Cancer contract.

Medicines

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

Requires Improvement

Diagnostic imaging

Staff followed systems and processes safely to administer, record and store contrast in line with the provider's policy. Staff performed a set list of checks prior to giving patients contrast as part of their CT examinations. Staff asked patients about kidney problems, allergies and about some types of medications which could interact with the contrast agents. These checklists were signed by the patient and stored electronically on the booking system. The service had a new IR(ME)R audit schedule, and an audit was planned for later this year. We requested the latest audit results for these checks, but they were not provided. This meant the provider could not be assured audits were being undertaken and results acted upon. After the inspection, the service provided evidence of a centralised spreadsheet showing all audit submissions for all PET-CT sites. However, this data only went up to March 2021.

Contrast media and other medicines were stored correctly. We saw warming cabinets within the scan room for the stored of contrast, and fridges in the radiopharmaceutical preparation room where the vials of radiopharmaceutical fluorodeoxyglucose were stored prior to injection.

The service had processes to ensure the right radiopharmaceutical and activity was sourced, prepared and injected into the correct patient. Radiopharmaceuticals were ordered in advance and according to the vetted request. Depending on the number of patients on the list for the day, the service could have up to three separate deliveries of radiopharmaceuticals. This was because the half-life of the isotope was quite short and would not last all day. Staff manually drew up and checked the activity of the injection using a tool on the booking system which helped calculate the volume of radiopharmaceutical to draw up based on the time of injection and half-life of the radioisotope. Injections were entered onto the system and all injections were double checked and countersigned by a second nuclear medicine practitioner.

Radiologists held appropriate IR(ME)R practitioner licenses for the administration of each radiopharmaceutical. These licenses were stored and coordinated centrally at the provider headquarters to ensure they were up-to-date and reflected the types of examinations being undertaken in the service. We reviewed the license for the unit and found it was in date. Information in them reflected the examinations undertaken with a clear line of delegation for injecting radiopharmaceuticals. However, we saw the documents giving authority to order and inject radiopharmaceuticals still referred to the old Administration of Radioactive Substances Advisory Committee certificate number. This meant important documentation was not reviewed and updated at a corporate or local level.

Incidents

The service did not always manage patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents but lessons learned were not always shared with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. All staff members had access to the incident reporting system. There was a clear policy and pathway to guide staff to identify and report incidents. The service had not recorded any never events. There had been no serious incidents reported in the past twelve months. Staff received feedback from investigation of incidents through the providers 'Risky Business' newsletter every month. Areas identified for improvement centred mostly on uploading current versions of documents to the central computer. For example, the patient group direction used for the administration of contrast for the CT service was available in hardcopy onsite, but not available on the central computer. After the inspection, the service supplied evidence to show this had now been rectified.

Requires Improvement

Diagnostic imaging

Managers did not always share learning with their staff about incidents and learning that happened elsewhere. There was a serious incident reported from another Alliance Medical PET-CT centre. No staff we spoke to were aware of this incident, or any wider learning from it. This was not in keeping with the providers incident management framework.

The unit had suffered two incidents regarding radioactive contamination in June and September 2021. One incident had been investigated and learning shared with staff, the other had actions taken but no evidence of learning shared. However, there had been no radiation incidents of accidental and unintended exposures in the past year that required notification to CQC under IR(ME)R 2017 or to the Health and Safety Executive under Ionising Radiation Regulations 2017 requirements.

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

Are Diagnostic imaging effective?

Inspected but not rated

We inspect but do not currently rate effective for diagnostic imaging.

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. Policies and procedures were made available to staff at provider and site specific level for the service. For example, in relation to Ionising Radiation Regulations 2017 which regulate the protection against exposure to ionising radiation due to staff roles. The scanning protocols and procedures were reviewed and approved by a consultant radiologist and IR(ME)R practitioner license holder in the case of PET scanning.

Staff understood and followed best practice guidance including Ionising Radiation (Medical Exposure) regulations 2017 (IR(ME)R).

The service ensured radiation doses were kept as low as reasonably practicable. Doses for each PET scan were pre-defined and measured to ensure the correct amount of radiopharmaceutical was used for each patient.

The service had an image optimisation team who reviewed around 200 scans for each centre per month. Images were graded one to five, one being the poorest score and five the highest. Image and reporting quality were audited within the service and compared to national outcomes across the organisation. We requested the latest image quality audit but were not provided with it. The service could not be assured the quality of reporting was adequate.

The service ensured it identified and implemented relevant best practice and guidance, such as National Institute for Health and Care Excellence (NICE) guidance. Staff signed to say they had read and understood the policies and procedures. When policies and procedures were updated, staff were advised by the organisation or registered manager of the change and often updated policies were highlighted and discussed at team meetings. Significant changes were also discussed as part of weekly 'bronze' calls which all registered managers in Alliance Medical Limited attended. These calls were also recorded and disseminated across the organisation.

Requires Improvement

Diagnostic imaging

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Patients were provided with specific instructions relating to eating and drinking prior to their scan within the appointment/booking information. This included fasting and only drinking water for a period of time.

There were facilities for hot and cold drinks plus biscuits for patients after they had their scan. Patients were recommended to sit in the waiting room while they had a drink and biscuit before leaving their appointment.

The service had processes for vulnerable patients who required pre-examination fasting or drinking. Diabetes management was considered at the initial safety review. If patients had type one diabetes, they were booked for their scan late morning. This enabled the patient to have their insulin, breakfast and then have nothing orally for four hours. Patients with type two diabetes had earlier morning appointments to enable them to miss medication and breakfast and so be suitably fasted for their appointments. The blood sugar levels of patients could be checked on arrival at the centre if required.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and to see if they were comfortable.

The scanning procedures were painless, but staff monitored and checked with patients throughout the scan to ensure they were comfortable. Staff assisted patients to access the scanning machine and helped position them appropriately.

No pain-relieving medicines were available within the service.

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.

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system they could all update although the service did not yet have access to the acute trust radiology booking system on the site.

The service participated in relevant national clinical audits. The service regularly reviewed the effectiveness of care and treatment through local audit and national audit with a structured audit programme. These audits included a monthly hand hygiene, an annual image quality and an annual IR(ME)R audit. The service was accredited by the Quality Standards for Imaging.

All PET-CT reporters were included in the national programme of audit scheme. This was a randomised 10% surveillance audit undertaken by auditors independent to the reporting clinicians. This was a centrally coordinated audit process carried out by the organisation. The results were held centrally, with feedback provided throughout the year to reporters to allow for reflection and improvement of practice.

Requires Improvement

Diagnostic imaging

Competent staff

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

Staff were usually experienced, qualified and usually had the right skills and knowledge to meet the needs of patients. New staff were provided with induction training which included a one-day corporate induction and managers gave new staff a full induction tailored to their role before they started work. A mentor was allocated to new staff and provided support with their induction programme and through their six-monthly probation period.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers supported staff to develop throughout the year with constructive appraisals of their work. All but one member of staff working at the service over the past year had received an annual appraisal.

The annual appraisal was linked to a pay review and completed jointly by the staff member and the registered manager. Topics discussed included mandatory training, core values and behaviours, career conversation, and a learning development review. A further mid-year review of individual objectives also took place.

Managers made sure staff received any specialist training for their role by identifying any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. All staff had undertaken either undergraduate or postgraduate training in nuclear medicine and had attended further training courses to learn new skills. For example, staff were given the opportunity to attend a variety of specialist courses at a centre of excellence in cancer care. Role specific training was available to staff in addition to the mandatory training. Administrative staff told us they could access more training at hospitals in Manchester and Southampton.

It was optional for staff to complete training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. No staff had completed the training since 2019. Dementia awareness and Mental Capacity Act training did not appear on the mandatory list of training subjects' staff were expected to maintain. This meant staff were not up-to-date on how to manage vulnerable patients with extra and mental health needs.

Staff who administer radiopharmaceutical medicines as part of clinical nuclear procedures should receive appropriate, specific training and demonstrate competence in the appropriate procedures (British Nuclear Medicine Society Professional Standards Committee, 2016). However, we found medicines management was optional training for staff. Of the four staff this applied to, two had expired training, one had not started training and did it not appear on the training record for one member of staff. This meant staff did not have or maintained their competency to administer radiopharmaceutical medicines and was not in keeping with the providers medicines quality policy and procedure (2021).

The service ensured relevant staff continued to maintain registration with relevant bodies. Managers also explained if a staff member was required to submit evidence of their continuous professional development as part of their re-validation, they would be given time and support during work hours to complete this. The service held records to show the professional registration for the clinicians was checked annually with the professional body. For example, radiographers were registered with the Health and Care Professions Council.

Role specific continuous development and maintenance of existing skills and competencies was an ongoing process. For example, peripheral vascular device insertion. Audits took place monthly to ensure staff maintained their competency and provided good outcomes for patients during their appointment at the centre. One radiographer had attended a radiation protection supervisor course and had recently assumed the role of clinical lead.

Requires Improvement

Diagnostic imaging

Multidisciplinary working

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

Staff contacted wards, surgeries and other health care professionals to discuss any specific health care needs in preparation for the scan. They telephoned all patients or their carers to discuss the preparation needed and confirmed the conversations with an email or letter.

Staff worked closely with referring consultants from the acute trust and IR(ME)R practitioner licence holders and other designated reporters. Liaison and communication took place by telephone, email and in face to face meetings.

A monthly meeting was held where the medical physics expert and/or the radiation protection advisor from the acute trust could attend. The purpose of the meetings was to identify various topics for discussion including emergency contingency plans, any reported radiation incidents and review of the monthly radiation scenario training provided to staff. We saw minutes of these meetings which showed they were last attended in 2015. Managers explained meeting minutes were held centrally. We saw minutes from September 2021, which showed evidence of shared learning. All meeting minutes were made available to staff on a central database.

Seven-day services

Key services were available seven days a week to support timely patient care.

The service provided PET-CT scans on Monday to Friday from 07.30 am to 7.30 pm. CT scans were provided on Saturday and Sunday from 07.30 am to 07.30 pm.

Health promotion

Staff gave patients limited practical support and advice to lead healthier lives due to the nature of the service.

There was limited health promotion available to patients in the centre as information provided related to the procedure being undertaken. Patients were advised not to smoke for six hours prior to the scan and were provided with information regarding when they could eat or drink before and after the 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.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. If staff felt a patient lacked the capacity to consent to the procedure, they would seek further advice. Patients were provided with written and verbal information prior to their appointment to enable them to understand the planned diagnostic test.

Staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, training records did not support this. According the training matrix, clinical staff had not received or kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Requires Improvement

Diagnostic imaging

Are Diagnostic imaging caring?

Good

We have not rated caring before. 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.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Each patient was provided with a cubicle known as the uptake room, to change into any gown or clothing needed. Each cubicle had a basket for the patients' belongings to be stored safely. The cubicles had close circuit television (CCTV) which was covered by a curtain when patients were changing. The CCTV was used to enable patient's privacy but also so staff could ensure their safety. There was signage to inform patients of the use of CCTV.

Patients said staff treated them well and with kindness. We saw staff spoke to patients in a friendly and considerate manner and gave a high standard of care. Patients were offered a chaperone if requested.

We spoke with patients and reviewed patient feedback from October 2021. This showed 97% of patients were either satisfied or very satisfied and 94% would recommend the service to family and friends.

Staff kept patient care and treatment confidential. A room was available if patients wished to have a private conversation on arrival.

Staff also took care not to eat or drink in the back office as this was in view of the waiting area where fasted patients waited for their appointment time.

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 emotional support and advice when they needed it. This included allowing patients who were anxious about having a scan to attend ahead of booking so staff could show them around the unit, talk through the procedure shown equipment before they received their injections, so they were not worried about the scan.

Staff demonstrated empathy when having difficult conversations and a separate room was available for patients to be given distressing news.

Staff understood the emotional and social impact a person's care, treatment or condition had on their wellbeing and on those close to them. Patients told us staff understood the sensitive nature of the treatment and took this into account when speaking to them.

Requires Improvement

Diagnostic imaging

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.

The unit specialised in PET-CT scans and staff ensured any specific concerns were addressed before scanning commenced. For example, how radio-active they would be and for how long.

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment. Patients told us they were provided with a wide range of documentation to explain their treatment and staff were gained their consent and explained each procedure. Staff made sure patients and those close to them understood their care and treatment. Patients with spoke with had told us they were happy with the treatment provided and had no complaints.

Patients and their families gave positive feedback on the service and their treatment and staff supported them to do this. Staff supported patients to make advanced decisions about their care as patients were provided with information in advance of their appointment to inform them about the treatment procedure and were available for any queries.

Are Diagnostic imaging responsive?

Good

We have not rated responsive before. 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 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 service was commissioned by an acute NHS trust to patients referred through the NHS.

The service provided PET-CT scans performed by specialist staff on five days and different staff from the provider carried out CT scanning on Saturdays and Sundays.

Facilities and premises were appropriate for the services being delivered. The environment was appropriate, and patient centred. The waiting room was small but adequate. Seating was available for the number of patients and relatives attending the clinic and allowed for social distancing. There was one toilet available, for patients and visitors to use before the patients had their injections. There was another toilet exclusively for patients receiving radiopharmaceuticals, to prevent the risk of cross contamination.

The service had systems to help care for patients in need of additional support. For those patients coming from the inpatient wards, timing was considered to support their other medical needs. For example, patients' medicines and treatments were considered and appointments fitted around the needs of the patient as well as dietary needs including for diabetic patients where fasting was required.

Managers monitored and took action to minimise missed appointments. Information about the unit and the procedures were provided with the appointment details. Staff were also available by telephone to discuss any concerns. When

booking appointments, staff considered the time and location of each patient. The first appointments of the day were often used for people in the local area. This meant if the appointment needed to be cancelled, the staff would ring the patient and delay them leaving, instead of patients already travelling a longer distance. Patients arriving by ambulance were accommodated in line with availability of transport.

Managers ensured patients who did not attend appointments were contacted. From 1 April 2021 and 30 September 2021 there were 30 appointments where the patient did not attend. This data was monitored centrally, and we saw the report also held specific information about why an appointment was missed. Managers explained if there was no obvious reason for the missed appointment, they would contact both the referrer and patient to seek to re-appoint the scan as soon as possible if it was still required.

There was enough car parking, including disabled parking, available nearby to the centre on the hospital site with charges set by the acute trust. Public transport was available and accessed the hospital site.

Meeting people's individual needs

The service was not always inclusive but did take account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health needs, learning disabilities or dementia, received the necessary care to meet their needs. However, training had not been undertaken or updated for dementia training as no staff had undertaken it since 2019 and it was not considered part of the mandatory training subjects required by the provider.

Information was provided to service users before appointments, which included contact details, hospital map and directions, consultants name and any information about fasting required. We asked staff if easy read information was available, but they were unsure. Where a patients first language was not English, translation services either by telephone or face to face were used. Staff told us relatives were never used to translate due to the complexity and safety of the scans.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. For patients who were visually impaired, staff ensured an appropriate person would be able to read the safety questionnaire and consent questions and complete the form on the patient's behalf. Guide dogs were able to enter the building but no further than the waiting area.

The service managed care of vulnerable service users by allowing a double appointment for patients living with dementia or learning disabilities. For patients who required support from their carer, the carer was able to stay with the patient for the PET scan but not for the CT scan. The carer would be able to talk to the patient from the control room.

Patients who suffered with claustrophobia could find the scan daunting. Patient were encouraged to visit their GP and obtain a prescription for a sedative. The staff liaised with the patient regarding the optimum time to take the sedative to correspond with the scan time. Additionally, staff told us they would invite patients into the scanner to see and lie in it before their actual appointment.

There was limited access to communication aids to help patients become partners in their care and treatment. The service did not have information leaflets available in other languages spoken in the local community or an 'easy read' format. Information posters in the centre were positioned to high up for patients in wheelchairs, the font was small and not easily read and there was no braille provision for visually impaired patients.

Staff told us they would use a translation service to verbally explain if needed. Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers for deaf patients when needed. Translation and interpretation services were available on request through a telephone service line for patients whose first language was not English. Arrangements could be made to support patients with the provision of British sign language. A hearing loop was available at reception and was portable and could be moved around the unit.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to scanning and reporting for patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The contract was commissioned by NHS England and required patients to be scanned and the images together with the associated report returned to the referring clinician within seven days of receipt of the referral. The exception to this was if there was a clinical indication for the scan to be booked for a specific date such as treatment or surgery.

Managers worked to keep the number of cancelled appointments to a minimum. Over the past year, 30 appointments had been cancelled for a non-clinical reason. This was mainly due to failure of patient transport; the radioisotope not being delivered on time or being delayed by the manufacturing process. The radioisotope was a form of natural elements used to pass through the body and be detected by the scanner. A leaflet was sent to patients explaining the process of the isotope being made in a facility in North Staffordshire and transported by road to the centre.

The service managed 'did not attend' rates. When patients did not attend a pre-booked scan, a reminder letter was sent with a further appointment. Staff attempted to telephone the patient to establish the reason for the absence and make sure the scan was rebooked. Should contact not be successful or the second appointment not attended, the administrative staff contacted the referrer and discussed the next course of action.

Managers and staff worked to make sure patients did not stay longer than they needed to. 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.

Patients were offered a choice of appointments and appointments were available in other areas, to ensure patients were seen promptly. Administrative staff discussed capacity across the region. If it was not possible for a patient to be seen in Taunton, they were allocated an appointment, with the patients' agreement, in another centre.

Same day or next day appointments were available if needed. The patient was contacted by telephone to complete the booking process. Where reasonable, the next available appointment space was allocated. If needed, a longer working day was planned to meet demand.

Patients were kept informed of any delays once they arrived in the department. Patients were given the choice to wait or come back in a set amount of time later.

The diagnostic service ensured it supported achievement of national cancer waiting standards, including implementation of rapid diagnostic and assessment pathways. As part of the monitoring process under the NHS England national cancer contract, the service reported on its reporting turnarounds on a weekly basis to NHS England. Data showed between 1 January 2021 and 31 October 2021, the service had an average turnaround of 3.93 days from referral to report. Overall, 88.7% of patients had their referral and report turnaround in under seven days.

Requires Improvement

Diagnostic imaging

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 and investigated them.

The service clearly displayed information about how to raise a concern in patient areas. The organisations concerns and complaints leaflet was available in reception. Patients told us should they need to raise any concerns or a complaint they would start by speaking to the staff.

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

The service had an in-date complaints and concerns policy stating the roles, responsibilities and processes for managing complaints. The interim registered manager was responsible for dealing with all complaints. Complaints were initially responded to within two days by telephone or email depending on patient preference. The unit had few complaints and a high level of patient satisfaction.

Are Diagnostic imaging well-led?

Requires Improvement

We have not rated well-led before. We rated it as requires improvement.

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.

Leaders had the skills, knowledge, experience and integrity they needed both when they were appointed and on an ongoing basis. The interim registered manager was based at the centre two days a week and visible and approachable to staff. However, they had only been responsible for the centre for two weeks and had replaced the registered manager who was absent from work. Support was provided to the registered manager by a regional manager. The regional manager and registered manager met every two months. This provided the regional manager with the opportunity to speak to all staff on site during their visit. Staff we spoke with were aware of the leadership roles and understood the reporting structure.

The interim registered manager had applied to add Taunton to their current registration as they were already a registered manager for another Alliance Medical Limited PET-CT centre. Upon appointment, the interim manager had been provided with a corporate induction training programme, the content of which had been appropriate for management staff. For example, training included staff management, budgets and financial constraints. The interim registered manager had achieved formal nationally recognised management qualifications prior to being employed by the organisation. The interim registered manager understood the needs of the service well, through attending regional and national meetings and liaising with the commissioners of the service.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

Requires Improvement

Diagnostic imaging

The provider has a clear vision and a set of values, with quality and sustainability as the top priorities. The organisation had developed a corporate vision, values and strategy which had been shared with the staff. A strategy wheel had been produced by the organisation together with information booklets which had been provided to staff. The interim registered manager described the aim, which was to engage staff and improve communications across the organisation. Leaders understood the challenges to quality and sustainability, and they could identify the actions needed to address them.

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.

The staff we spoke with during inspection were open and friendly and spoke positively about working at the unit. They felt supported, respected, valued and proud to work for the organisation.

The service sought more information when patients' feedback showed dissatisfaction. We reviewed five policies and procedures and saw all had equality impact assessments completed. This ensured they had considered the needs of staff and patients and reflected on the potential effects the policy may have on people with protected characteristics.

The provider conducted a survey of staff, 'Response to the Pandemic Survey 2021' where 78% respondents agreed or strongly agreed with the statement that they were proud to have been part of Alliance Medical Limited response to the pandemic.

Staff were aware of the providers whistleblowing policy and the service had a freedom to speak up guardian.

Governance

Governance processes were not always effective. Staff at all levels were clear about their roles and accountabilities and had opportunities to meet, discuss and learn from the performance of the service.

Governance arrangements for oversight of staff training were not accurate at local level as there were inaccuracies in the training matrix. The training needs analysis showed the provider had 28 mandatory training subjects. Training subjects for staff ranged from 15 to 25. Therefore, no staff in the unit had completed all their mandatory training.

The certificate for the administration of radioactive medicinal products which was issued to the overseeing consultant for the unit and contained in the providers procedure for delegating radiopharmaceutical responsibility, was out of date and had expired in August 2021 but had been replaced by a new practitioner licence in line with changes to registration of licences under IR(ME)R 2017. However, we saw that both the authority to inject and authority to order schemes of delegation still referenced the out of date licence number. This meant important legal documentation was not reviewed and updated at a corporate or local level.

Checks and audits were carried out to assess the quality of the service provided to patients. The centre underwent an annual quality assurance inspection which showed an overall compliance score of 74%. The service did not have a target to achieve but excellent was considered over 95% and good 80-94.5%. Areas identified for improvement centred mostly around uploading current versions of documents to the central computer. For example, the patient group direction used for the administration of contrast for the CT service was available in hardcopy onsite, however, was not available on central computer. After the inspection, the service supplied evidence to show this had now been rectified.

Requires Improvement

Diagnostic imaging

There were structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. Staff at all levels were clear about their roles and understood what they were accountable for, and to whom. Policies and procedures were available to staff on the company website and were reviewed regularly and updated in line with national guidance and legislation. Staff could demonstrate how to access policies and guidance when needed.

Medical physics support was sought through a third-party provider, and the service ensured open contact and enough advice was available. Staff were clear on who their radiation protection advisor and medical physics expert was and could describe how to contact them. We saw evidence in incident logs of the medical physics experts' input in incidents involving radiation or requiring advice.

The service ensured all staff underwent appropriate checks as required by Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff were recruited in line with national guidance and the effective recruitment process ensured staff were competent, capable and confident in their area of practice. The registered manager was supported in the recruitment processes by the organisation's human resources department. Checks on staff continued professional registrations, where applicable, were undertaken annually.

Feedback was given to the unit during quality calls and unit managers across Alliance Medical Limited. They met monthly to talk about recent audits, changes or learning from incidents and patient feedback.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They documented some risks but did not review the risk register.

The provider had a current incident management framework and associated procedures policy. The unit had a risk register with 33 risks. All the risks were all opened between 24 – 29 April 2019 and should have been reviewed in October 2020; none had been reviewed. There was no target or current risk rating for any risk. We requested minutes of the weekly 'bronze' calls in which all registered managers in Alliance Medical Limited attended for evidence of discussion of risk. We were provided with the COVID-19 weekly updates. These did not show any discussion of risk or learning.

The unit had suffered two incidents regarding radioactive contamination in June and September 2021. However, while there was some mention of risks with radiation, there were no listed risks on the register concerning radiation spillage, contamination or leak.

The interim registered manager said they had identified a risk as there were not enough administration staff for the unit. This had not yet appeared on the risk register.

The provider has a programme of clinical and internal audit to monitor quality and operational issues.

The service had back up emergency generators in case of failure of essential services. The service had remote primary and acute care system support from 8 am and 8 pm seven days a week. Scanning did not take place outside of these hours. Staff were aware of how to contact picture archive communication support if needed.

Requires Improvement

Diagnostic imaging

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.

The unit had simple systems all staff could access. Staff demonstrated how easy it was to pull data from the system and could present this in several formats to help with understanding and analysis of the unit's day-to-day running.

Quality information was collated through patient, referrer and staff surveys, clinical audits, service reviews and key performance indicators. The service had an established electronic information and patient record system and systems were password protected.

The service had a range of policies including medicines quality, information security and procedures relating to radioactive materials and licences. The confidentiality of electronic patient information was maintained, and staff had access to the general data protection regulation policy.

The website for the location needed updating to include patient information in an easy read format.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

Patient's views and experiences were gathered and acted on to shape and improve the services and culture. The unit asked for feedback following each scan. Feedback was used to evaluate the service and the feedback we reviewed was mostly positive.

Staff meetings had not always been held each month. However, the interim registered manager planned to re-introduce regular staff meetings.

There was transparency and openness with all stakeholders about performance and the latest Quality Accounts 2020/1 were available on the providers website to download.

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.

Leaders and staff strived for continuous learning, improvement and innovation through participating in further education at cancer specialist hospitals. The provider encouraged staff to actively seek out further education to improve delivery of the service.

Managers planned continuous development of the unit by increasing the size of the team, promoting the use of an automated injector device for the contrast and explore the development of different types of scans they could undertake to improve patient experience.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Persons providing care or treatment to service users must have the qualifications, competence, skills and experience to do so safely. This includes dementia awareness training, Mental Capacity Act, Deprivation of Liberty and Ionising Radiation (Medical Exposure) Regulations (IM(ER)R) 2017 as mandatory training subjects. Regulation 12 (2) (c) Dementia training was not included in the services mandatory training and there was no evidence of recent training completed by staff. Ionising Radiation (Medical Exposure) Regulations (IM(ER)R) 2017 was not recorded as a mandatory training subject, when this is a legal requirement.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider should assess, monitor and improve the quality and safety of the services provided. This includes an up-to-date risk register more reflective of the risks faced in the carrying on of the regulated activity. Regulation 17 (2) (a) The risk register showed multiple open risks with no evidence of review or update since opening.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes must be established and operated effectively to ensure compliance with regulations and adhere to the provider's own policy regarding quality assurance. Regulation 17 (1)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance Governance arrangements for oversight of staff training must be more accurate and effective. Regulation 17 (2) (d) and (i) Figures provided on site for staff training compliance were not up to date and did not reflect actual training undertaken by staff.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Pause and check guidance must be performed for every patient before administering injections or scanning the patient. Regulation 12 (1) (2) b Not all patients undergoing imaging had a positive identification check prior to their scan.