

Paul Strickland Scanner Centre

Quality Report

<Mount Vernon hospital Northwood Middlesex HA6
2RN>

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

Ratings

Overall rating for this location

Good



Are services safe?

Good



Are services effective?

Not sufficient evidence to rate



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



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

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

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

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

Summary of findings

Overall summary

Paul Strickland Scanner Centre is an independent operator and is situated within the grounds of Mount Vernon Hospital site.

We carried out the unannounced inspection on 06 December 2018.

We inspected the diagnostic facilities for adults using our comprehensive inspection methodology.

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

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

The main service provided was diagnostic services.

Services we rate

We rated it as good.

We found good practice in relation to diagnostic imaging:

- There were effective systems in use to keep people protected from avoidable harm. Staff were provided with safety related training, including safeguarding vulnerable people. There was access to professional guidance, policies and procedures to support their work.
- There were sufficient numbers of staff with the necessary skill, experience and qualifications to meet patients' needs. Staff had access to additional development opportunities identified through their performance reviews.
- Equipment was maintained and serviced in line with expectations and medicines were managed safely. The environment was suitable, accessible and visibly clean. Staff followed infection prevention and control practices.

- Patient records and scans were complete, up to date and stored securely to avoid unauthorised access. Referral to scan times and scan to reporting times were within the agreed protocols and expected ranges.
- The staff worked well with both internal and external colleagues to ensure the delivery of a responsive service. Appointments were available at times convenient to patients including evening, weekends and at short notice.
- Staff considered the individual needs of patients using the service and were kind and caring towards them, respecting their dignity and emotional needs.
- The service acted on the feedback from patients and staff to continuously improve the service.
- The senior team had the right skills and experience to lead. They were supportive and led by example. Staff understood the vision and values of the service and the culture was positive, with staff showing pride in their work.
- Performance outcomes and risks were monitored and acted upon. Staff recognised and valued the importance of learning and continuous improvement.

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

- The provider should ensure that there is a formal audit process for 'pause and check', which is a process that encourages staff to check clinical details with the patient to reduce the risk of errors.
- The provider should ensure that the resuscitation equipment is checked each day the clinic is operational, including at weekends.
- The provider should ensure that there is a clear system of contrast agent stock rotation.
- The provider should fulfil their responsibilities under the Workforce Race Equality Standard.

Dr Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South)

Summary of findings

Our judgements about each of the main services

Service

Diagnostic imaging

Rating

Good



Summary of each main service

We rated diagnostic imaging as good. This was because there were sufficient staff with the required skills and experience to provide the service. The service was provided in line with the national guidance and diagnostic reference guide.

Staff provided care in a compassionate way and their feedback was positive. Patients could access the service when needed and their individual needs were recognised and cared for. We saw strong leadership and governance of the service, and staff spoke positively about the culture of the service, and the organisation.

Summary of findings

Contents

Summary of this inspection

	Page
Background to Paul Strickland Scanner Centre	6
Our inspection team	6
Information about Paul Strickland Scanner Centre	6
The five questions we ask about services and what we found	7

Detailed findings from this inspection

Overview of ratings	11
Outstanding practice	30
Areas for improvement	30
Action we have told the provider to take	31

Good 

Paul Strickland Scanner Centre

Services we looked at

Diagnostic Imaging

Summary of this inspection

Background to Paul Strickland Scanner Centre

Paul Strickland Scanner Centre provides magnetic resonance imaging (MRI), computerised tomography (CT) and positron emission tomography-computed tomography (PET CT) diagnostic services for adults. It provides NHS and private scanning services to a large

geographical area, including Hertfordshire, South Bedfordshire, East Berkshire, South Buckinghamshire and North West London. The unit is registered with the CQC to undertake the regulated activity of diagnostic imaging.

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

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and a specialist advisor with expertise in radiological services. The inspection team was overseen by Head of Hospital Inspection Terri Salt.

Information about Paul Strickland Scanner Centre

Paul Strickland Scanner Centre (PSSC) is located on grounds of Mount Vernon Hospital part of the Hillingdon Hospital NHS Foundation Trust to which it pays rent. The

Centre is co-located with Mount Vernon Cancer Centre which is part of the cancer service provision for East and North Herts NHS Trust. PSSC provides CT, MRI, and PETCT. Ninety two percent of patients treated are NHS patients.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as good because:

- There was a good open incident reporting culture within the unit and there was an embedded process for staff to learn from incidents.
- Staff were trained to recognise adults at risk and were supported by the provider's safeguarding adults' and children policies.
- There were sufficient staff with the necessary skills, experience and qualifications to meet patient need.
- Patient risk was assessed and managed to minimise patient harm.
- The unit was visibly clean and the environment was pleasantly decorated and comfortable for patients.
- Equipment was serviced in line with requirements and regulations for safe use were in place.
- Medicines were administered and stored safely.

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

- The provider should ensure that the resuscitation equipment is checked each day the clinic is operational.
- The provider should ensure that there is a clear system of contrast agent stock rotation.

Good



Are services effective?

Not sufficient evidence to rate

- Policies, procedures and guidelines were up to date and based on National Institute for Health and Care Excellence (NICE) guidelines, relevant regulations and legislation.
- The provider was accredited in accordance with ISAS Standard v3.0, 2017 Imaging Services Accreditation Scheme (ISAS).
- There was a clinical audit group which oversaw development and monitored the implementation of the centre's clinical audit programme.
- There were systems in place to inform staff of any amendments to policies or procedures.
- There was good multidisciplinary working with colleagues inside and outside the centre to meet patients' needs.
- Staff were competent to do their jobs and develop their skills. There were opportunities for them to discuss professional development.

Not sufficient evidence to rate



Summary of this inspection

- Staff demonstrated a good working knowledge of the consent process.

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

- The provider should ensure that there is a formal audit process for 'pause and check'.

Are services caring?

We rated caring as good because:

- Patients were treated with dignity, respect and compassion. This was reflected in the positive comments written in patient comment cards, as well as feedback to inspectors from patients and relatives during inspection.
- Patients received information in a way which they understood and felt involved in their care. Patients were always given the opportunity to ask staff questions, and patients felt comfortable doing so.
- Staff provided patients and those close to them with emotional support; all staff were sympathetic to anxious or distressed patients
- The service provided chaperones to those patients who required or requested one.

Good



Are services responsive?

We rated responsive as good because:

- The service was planned with the needs of service users in mind.
- The provider acted upon suggestions for improvements made by patients.
- There was a proactive approach to meeting the individual needs of patients. Staff in the unit had worked hard to ensure the needs of patients living with dementia and learning disability or who were anxious were taken into consideration.
- The appointments team called all patients due for MRI and PET CT scans to make an appointment and to explain the procedure.
- The provider extended the working day at times when demand exceeded capacity to meet the demand and additional clinics were run on Saturdays.
- The unit ensured a quick turnaround on the reporting of procedures.

Good



Summary of this inspection

- Patients could access services easily; appointments were flexible and waiting times short. Appointments and procedures occurred on time and patients were kept informed of next steps throughout the care pathway.
- The 2017 patient satisfaction survey showed 100% satisfaction with appointment date and time.
- There was a quality improvement team which engaged with patients to ensure information was accessible, clear and available in formats tailored to individuals and their carers.
- Complaints were acknowledged and investigated thoroughly. Learning arising from the investigative process was shared with staff.

Are services well-led?

We rated well-led as good because:

- The staff understood the vision and values of the service. They were realistic and reflected through team and individual staff member objectives.
- There was a clear governance structure, which all members of staff were aware of.
- Staff felt supported and were positive about their leaders.
- The centre had its own risk register and the manager had clear visibility of the local and corporate risks and were knowledgeable about the mitigating actions taken.
- Up to date policies and procedures were available to support staff in the delivery of safe and effective care.
- There was a culture of openness and honesty supported by a whistle blowing policy and 'Speak in Confidence' service.
- Managers were open to innovative ideas. There were plans to increase patient numbers, extend the service and ensure sustainability.
- The centre was also a research centre and was involved in many clinical trials to help find new treatments and encourage changes in practice. Research included innovative chemotherapy and immunotherapy treatment.
- The centre won international recognition for aspects of research which included PET-CT in head and neck cancer; whole body scanning in breast cancer and dose optimisation.
- Radiographers were awarded first prize for their e-poster 'Advancing care of patients with dementia during PET/CT imaging' in 2017.
- The UK Radiology Conference and the European Congress of Radiology accepted a poster on improving patient experience through ongoing feedback for presentation in 2017.

Good



Summary of this inspection

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

- The provider should fulfil their responsibilities under the Workforce Race Equality Standard.





Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Not rated	Good	Good	Good	Good

Diagnostic imaging

Safe	Good 
Effective	Not sufficient evidence to rate 
Caring	Good 
Responsive	Good 
Well-led	Good 

Information about the service

Paul Strickland Scanner Centre's main role is as a cancer imaging facility, supporting the on-going monitoring and staging of treatment rather than primary diagnosis; 70% of those treated are cancer patients.

All staff are employed by the centre, which operates between 8:00am and 7:00pm Monday to Friday. The service scans patients over the age of 18 years.

The centre has three MRI scanners (one of which is co-located in a nearby cancer centre); one CT scanner and two PET-CT scanners. There is a waiting and reception area, three toilets, a patient weighing and measuring area and a reporting room.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the services first inspection since registration with CQC, which found that the service was meeting all standards of quality and safety it was inspected against.

During the inspection, we visited all areas of the centre. We spoke with 12 staff including; the service manager, operations manager, radiologist, medical physics expert, superintendent radiographers, radiographers and administration staff. We spoke with three patients and four relatives. During our inspection, we reviewed four sets of patient records.

Activity (October 2017 to September 2018)

- In the reporting period October 2017 to September 2018, there were 18,071 patients scanned; of these 16,444 (91%) were NHS-funded and 1,627 (9%) other funded. Of these, there were 5,636 CT scans; 7,692 MRI scans and 4,743 PET-CT scans.

The service employed 5.4 whole time equivalent (WTE) radiologists; 22.4 WTE radiographers; 8.1 WTE radiography assistants; four staff responsible for IT/PACS/RIS; two physicists; six administrative staff and 3.3 WTE communication and appeals staff.

Track record on safety

- Zero Never events
- Clinical incidents - 26 no harm, 11 low harm, zero moderate harm, zero severe harm, zero death
- No serious injuries
- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA)
- No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA) No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-Coli

There were two complaints neither of which were upheld.

Services accredited by a national body:

- Imaging Services Accreditation Scheme July 2017 to July 2021
- International Organisation for Standardisation – information security management systems ISO 9001 October 2017 to October 2020

Diagnostic imaging

Services provided at the clinic under service level agreement:

- Clinical and or non-clinical waste removal
- Laundry service
- Building maintenance
- Grounds Maintenance

Are diagnostic imaging services safe?

Good 

We previously did not have the authority to rate this service. However, on this inspection we did have the power to rate and we rated it as good for safe

Mandatory training

- Annual mandatory training courses were undertaken and regularly updated. Mandatory training included 'face to face' and 'e-learning' modules. The provider had a standard of 90% for compliance and at the time of this inspection, 94% of staff had completed their mandatory training.
- Training compliance was monitored and staff received reminders when their training was due for completion. A member of staff told us mandatory training took place over two days each year and had to be completed in time for their annual appraisal.
- This training included fire safety and evacuation, health and safety, equality and diversity, infection prevention and control, moving and handling objects and moving and handling people/patients, safeguarding adults, safeguarding children level 2, customer care and complaints, basic life support (BLS) and data security awareness. Staff also completed Mental Capacity training as part of their mandatory training.
- We were assured staff working with radiation had appropriate training in the regulations, radiation risks, and use of radiation. Staff could provide evidence of training and were aware of the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R17) and were able to direct us the IRR regulations.

Safeguarding

- There was an appointed lead for adults and children's safeguarding who was trained to level two in both adults and children safeguarding. There was ready access to level three trained staff from the local NHS trust which was covered under the terms of the provider's service level agreement.
- The provider followed the local NHS trust safeguarding vulnerable adults and vulnerable children policies. There were contact details for the local authority safeguarding teams clearly displayed on posters in each clinical area and staff were familiar with the process of referral.
- All staff received safeguarding training as part of their initial induction and did refresher training every two years. We saw documentary evidence that there was 96% compliance with levels 1 and 2 safeguarding adults training and 98% compliance with levels 1 and 2 safeguarding children training.
- This met intercollegiate guidance: Safeguarding Children and Young People: Roles and competencies for Health Care Staff (March 2014). Guidance states all non-clinical and clinical staff that have any contact with children, young people and/or parents/carers should be trained to safeguarding level two.
- Staff were trained to recognise adults at risk and were supported by the provider's safeguarding adults' and children policies. Those we spoke with demonstrated that they understood their responsibilities and adhered to safeguarding policies and procedures. They were aware of the Department of Health (DoH) female genital mutilation and safeguarding guidance for professionals March 2016.
- The service made two vulnerable adult safeguarding referrals to the local authority between October 2017 and September 2018.

Cleanliness, infection control and hygiene

- The provider had infection prevention and control (IPC) policies and procedures in place which provided staff with guidance on appropriate IPC practice in for example, communicable diseases and isolation.
- All areas of the service were visibly clean. An external cleaning company was responsible for cleaning the

Diagnostic imaging

department and all activities were recorded on a daily check sheet. There was a twice-monthly environmental audit and compliance rates were between 92% and 95% from May 2018 to November 2018.

- Staff had access to hand washing facilities. Throughout the inspection, we found all staff were compliant with best practice regarding hand hygiene and were bare below the elbow. There was ready access to a supply of personal protective equipment (PPE), including gloves and aprons.
- Hand hygiene audits were completed to measure staff compliance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene.' These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene to reduce risk of cross contamination between patients.
- The unit IPC lead was responsible for supporting staff and they undertook two IPC audits each month. We saw that compliance rates from May 2018 to November 2018 were between 94% and 100%, where the standard was 100%. This dropped to 89% for August, which we saw referenced in September board meeting minutes.
- In response to this, the IPC lead developed an action plan that included increased observations as well as focussed discussions during team meetings. Hand hygiene compliance improved to 94% in September and 100% for both October and November. We saw e-mails from the IPC lead to all members of staff following each audit that outlined areas for improvement. A member of staff told us these e-mails contributed to improved infection prevention.
- There were no healthcare acquired infections between October 2017 and September 2018.
- Staff followed manufacturers' instructions and the provider's IPC guidelines for routine disinfection. This included the cleaning of medical devices, including MRI coils, between each patient and at the end of each day. We saw staff cleaning equipment and machines following each use. We reviewed all machines in use during this inspection, and saw they were disinfected as required.

- We watched staff as they followed NICE QS61 Statement 5, (People who need a vascular access device have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the device and its removal). They disposed of vascular access devices correctly in a contaminated sharps container.
- Waste was handled and disposed of in a way that kept people safe. Staff used colour-coded bags to identify the type of waste being disposed of. Bags were tagged when full; stored in a secured area behind the building and collected by a registered waste management company. Confidential waste was kept securely in a locked bin.
- Sharps bins were correctly labelled and placed close to the areas where medical sharps are used. They were appropriately sealed when full and stored safely prior to collection.

Environment and equipment:

- The scanning unit was in a purpose-built building adjacent to the main Mount Vernon hospital block. The layout was compatible with health and building notification (HBN06) guidance and was all on ground level floor. There was a staffed reception desk beside the patient waiting area. Toilet facilities for patients and relatives were accessible and situated close to the waiting area.
- There was a system to ensure repairs to equipment were carried out if machines and other equipment broke down. Repairs were completed quickly so patients did not experience delays to treatment. Servicing and maintenance of equipment was carried out using a planned preventative maintenance programme with the relevant machine manufacturers.
- During our inspection we confirmed that servicing for all equipment was within date. We saw that lead aprons and lead neck collar shields were recently audited and no actions were required.
- There was a designated area to weigh and measure patients. The weighing scales was labelled to confirm they were service tested.
- All relevant MRI equipment was labelled in accordance with recommendations from the Medicines and Healthcare Products Regulatory Agency (MHRA).

Diagnostic imaging

- Access to the MRI room was via a coded controlled door. There was signage on all doors explaining the magnet strength and safety rules. Room temperatures were recorded as part of the daily MRI checks and we saw temperatures were checked and were within the required range.
- We saw the fringe fields (the peripheral magnetic field outside of the magnet core around the MRI scanner) for each MRI were clearly displayed. This reduces the risk of magnetic interference with nearby electronic devices, such as pacemakers.
- Staff had sufficient space to move around the MRI scanner. All patients had access to an emergency call/panic alarm, earplugs and ear defenders during scanning. There was a microphone that maintained contact between the radiographer at all times and patients could have music of their choice played whilst being scanned.
- Scanning rooms were equipped with oxygen monitors to ensure that any helium gas leaking (quench) from the cryogenic vacuum flask used for storing cryogenics such as liquid nitrogen or liquid helium, would not leak into the examination room, thus displacing the oxygen and compromising patient safety.
- They were also fitted with an emergency quench switch which was protected against accidental use and initiated a controlled quench and turned off the magnetic field in the event of an emergency. The magnet was also fitted with emergency “off” switches, which suspend scanning and switch off power to the magnet sub-system, but will not quench the magnet. Staff we spoke with knew what actions to take in the event of an emergency quench situation.
- The resuscitation trolley was stored in the CT room. Equipment appeared visibly clean; single-use items were sealed and in date and emergency equipment was serviced. Emergency medicines were available in the event of an anaphylactic reaction.
- Records indicated resuscitation equipment was checked each day from Monday to Friday and was safe and ready to use in the event of an emergency.
- No CT scanning took place at the weekend and staff transferred the resuscitation trolley to a bay outside the scanning room at the end of Friday clinics in order to be accessible to other Saturday clinics. This process was approved by the local NHS trust that provided life support training to staff. However, since weekend staff did not carry out checks they did not have assurance that the resuscitation trolley was fully equipped.
- We were told that robust pre-clinical testing took place on the recently installed MRI scanner. The medical physics expert told us they routinely quality assured equipment. We saw evidence that radiographers did daily local checks at the beginning of each clinic.
- All imaging and medical equipment was managed in line with the provider’s managing assets policy.
- The provider had an appointed radiation waste advisor (RPA) as part of their service level agreement with the local NHS trust. Staff told us the RPA recently provided spills training which included a practical demonstration and role-play.
- There were local protocols for the use of unsealed sources of radioactivity (Local Rules for Radiation Safety PET-CT & EPR2010 SOPs). These included defining special designated areas; operating procedures that included minimising contamination, decontamination, as well as precautions in handling and disposal of radioactive waste.
- The medical physics expert monitored compliance with Environmental Permitting Regulations (EPR) radioactive waste disposal.

Assessing and responding to patient risk

- Staff assessed patient risk and developed risk management plans in line with national guidance. We saw magnetic resonance imaging patient safety questionnaires were fully completed and risks were managed well.
- The service had access to the emergency resuscitation team based in the host hospital who would attend in the event of an emergency. The service telephoned an emergency number that went through to emergency bleep holders in the hospital for immediate response; in addition, a member of staff would dial 999 for an emergency ambulance to attend.
- There were procedures in place for removal of a collapsed patient from the MRI scanner. There was an

Diagnostic imaging

MRI safe wheelchair available for patients to transfer them from the scanner. The new MRI scanner had a removable table that meant the patient could be wheeled out from the scanner on the table. The older scanner had an MRI safe fixed table which staff told us they practised the removal of a patient in an emergency.

- There were processes in place to ensure the safe transfer and clinical handover of patients and emergency procedures where the patient became unwell and required urgent medical treatment. There was one patient transfer to a local urgent and emergency care hospital department between October 2017 and September 2018 following their deterioration.
- The provider had a procedure for communication of critical, urgent and unexpected significant radiological findings. This procedure clarified the differing lines of communication, depending on who the referrer was.
- Staff explained the processes to escalate unexpected or significant findings both at the examination and upon reporting. These were in line with the services routine MRI guidance policy. They told us how unexpected findings were discussed with other colleagues and notified to the referrer as a matter of extreme urgency.
- Local rules, Radiation safety policy and IRMER procedures were all in place and current. The service had separate IRMER procedures in place to cover both PET-CT and CT.
- There were processes in place to ensure the right person got the right radiological scan at the right time. The Society and College of Radiographers (SCoR) recommends a 'pause and check' process for radiographers before and after an exposure is carried out. Magnetic resonance imaging (MRI) Local Rules were in place to ensure the risks associated with the use of MRI were minimised for patients, staff and others.
- Two staff completed 'pause and check' procedures. One member of staff referred to a checklist that their colleague simultaneously confirmed against the patient record. The checklist also included any previous surgery the patient may have had. We observed this process during inspection.

- However, there was no formal audit of pause and check procedures for inspectors to evidence. The registered manager told us they regularly observed staff but acknowledged they did not maintain formal records but would seek to do so in the future.
- There was a safety team whose responsibility it was to provide assurance that the centre had adequate systems and processes in place to ensure and continuously improve the safety of patients, staff and others.
- All referral forms included patient identification, contact details, clinical history and examination requested, and details of the referring clinician/practitioner.

Radiography staffing

- The provider's workforce planning covered all staff levels. The strategy was to ensure that there was sufficient staff to meet current demand, as well as to have a rolling programme of recruitment to meet increased demand due to the additional MRI scanner.
- Staff in the unit consisted of one registered manager, 5.4 whole time equivalent (WTE) radiologists; 22.4 WTE radiographers; 8.1 WTE radiography assistants; four staff responsible for IT/PACS/RIS; two physicists; six administrative staff and 3.3 WTE communication and appeals staff.
- Staff were recruited in accordance with NHS Code of Conduct principles for recruitment, pre-employment checks, selection and induction. Staff involved with recruitment completed the NHS recruiter training and all had diversity and equality training.
- All professionally qualified staff were on the appropriate registers (General Medical Council, Health and Care Professions Council) and were also members of their professional bodies. Contemporaneous records of registration, mandatory training, appraisals and continuous professional development were maintained.
- There was full radiographer rotation across MRI, PET-CT and CT that provided flexibility to support the demands of the service. Staffing levels in all areas were monitored to ensure safe, effective levels of operation at all times.

Diagnostic imaging

- We saw there was a local induction procedure for agency and bank staff which included an induction handbook that was signed off by the supervising member of staff.

Medical staffing

- There was a consultant radiologist and on-call medical team available during working hours as well as 24-hour resuscitation team emergency cover. There was a consultant led on-call service for varying time periods as determined by the requirements of a service level agreement with a local NHS trust.

Records

- Staff kept and updated individual patient care records in a way that protected patients from avoidable harm. Records were electronic and available for access by staff.
- All images and reports were sent via image exchange programme (IEP) to the referrer. Reports were sent via secure email to multidisciplinary teams and clinics.
- We saw the Radiology Information System (RIS) and Picture Archiving and Communication System was secure and password protected. Each staff member had their own personally identifiable password.
- Patients' personal data and information were kept secure and only staff had access to the information. Staff received training on information governance and records management as part of their mandatory training programme.
- The provider told us that IT accounts of staff who no longer worked at the centre were promptly deactivated.
- We reviewed three patient care records during this inspection and saw records were accurate, complete, legible and up to date.

Medicines

- We saw the service had current practitioners Administration of Radioactive Substances Advisory Committee (ARSAC) licenses in place. The provider told us there was a change to the legislation whereby a site license was also required. However, they were

informed by ARSAC that practitioner licenses were sufficient until their renewal date (2022). Nevertheless, they were currently in the process of applying for a site license.

- The provider used separate medicines suppliers for IV and oral contrast media for CT and contrast media for MRI. All other drugs were supplied by the on-site pharmacy.
- The provider had a medicines management policy which staff followed to ensure the safe use of medicines. There were no non-medical prescribers in the service. Contrast media for IV and oral CT were prescribed by the radiologists and radiographers administered as per the prescription.
- The provider had links with the on-site trust pharmacist and the link pharmacist assisted with the writing and renewal of patient group directions (PGD). Patient group directions are written instructions to help with the supply and administration of medicines to patients, usually in planned circumstances.
- We saw there were PGDs in place for radiographers to administer certain drugs. These included medicines for MRI imaging of abdomen and pelvis as well as fluids for flushing of peripheral & central venous access devices, as well as contrast medium.
- Medicines, including intravenous fluids, were stored securely. No controlled drugs were stored or administered as part of the services provided. Medicines requiring storage within a designated room were stored correctly, in line with the manufacturers' recommendations, to ensure they would be fit for use.
- We saw that there was no obvious stock rotation of contrast agent in the warming cupboard. The member of staff we spoke with told us there was a system of stock rotation but they acknowledged it was not immediately obvious and could be confusing to a new member of staff.

Incidents

- There were no never events between October 2017 and September 2018. Never events are serious incidents that are entirely preventable as guidance, or

Diagnostic imaging

safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

- There were no serious incidents reported by the service between October 2017 and September 2018. Serious incidents are events in health care where there is potential for learning or the consequences are so significant they warrant using additional resources to mount a comprehensive response.
- There were two incidents notifiable in accordance with Ionising Radiation (Medical Exposure) Regulations between October 2017 and September 2018. These related to PET-CT and resulted in no patient harm.
- Senior staff were aware of the requirements for reporting serious incidents to the CQC using the statutory notification route if this met the criteria, under Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.
- The provider had an internal incident reporting system and staff reported in line with the provider's incident management procedure policy. They carried out a six-month review of incidents to review the types of incidents and reporting areas. This review also explored any themes; incidents actioned; staff learning and areas for improvement.
- There were 37 reported incidents between April and September 2018. Of these, 17 were reported in CT; nine in PET-CT and seven in MRI. Eleven (30%) were minimal harm (eight of which were extravasation) and 26 (70%) were no harm incidents.
- The incident review included learning and actions; for example, following one incident it was agreed that there would be a single extravasation procedure developed for all three modalities where there were currently three separate procedures in place. Extravasation is when a chemotherapy medication or other drug leaks outside the vein onto or into the skin, causing a reaction. For reported data entry errors, some of the reasons for this were identified as further training requirements for administrative staff and a more suitable working environment. At the time of this inspection, administrative staff had already moved into more spacious working conditions.
- Staff told us they completed an for every adverse incident, clinical and non-clinical, accident or near miss. They said that all incidents were investigated and learning shared with staff at team meetings and in e-mail. We saw evidence of this shared learning recorded in team meeting minutes.
- A member of staff told us of one such incident report they made where an in-patient from a local hospital attended for a scan. It became apparent from the history taken from the patient that they had a communicable disease, information that ward staff did not share in advance. Centre staff very quickly isolated the area and acted in accordance with their infection prevention and control policy. This was logged as an incident and subsequent learning was shared in team meetings.
- From March 2015, all independent healthcare providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Duty of Candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- The service had a duty of candour policy in place. The policy defined when the principles of duty of candour should be followed. Senior staff members explained the process to implement the duty of candour following an incident which met the requirements.
- Staff were aware of the DoC regulation and described it as being open and honest with patients and ensuring they received a timely apology when a notifiable safety incident occurred. The Duty of Candour regulation was not applicable to any incident which occurred between October 2017 and September 2018.

Are diagnostic imaging services effective?

Not sufficient evidence to rate 

We do not rate effective.

Diagnostic imaging

Evidence-based care and treatment

- We reviewed policies, procedures and guidelines produced by the service. These were based on current legislation, national guidance and best practice, these included policies and guidance from professional organisations such as National Institute for Health and Care Excellence (NICE), as well as the Royal College of Radiologists and the Society and College of Radiographers (SCoR).
- Staff were kept up-to-date with changes in policy and procedures, ensuring practice was evidence based. We saw staff signed a sheet which indicated that they had read the updated policy. Staff we spoke with said changes to practice and policies were highlighted during staff meetings and emails. They said any amendments to policies or procedures were also notified to them.
- There was a clinical audit group which oversaw development and monitored the implementation of the centre's clinical audit programme.
- The service had a clinical audit policy that set out the guidance around clinical audit. There was a lead radiographer for research and clinical audit, as well as a clinical audit group, which met regularly and worked to agreed terms of reference. The purpose of this group was to promote audit within the department and support staff undertaking audit work. It also reported on compliance against existing guidance or internal standards. There was an active cycle of audits spread throughout the year.
- The service held quarterly discrepancy meetings in accordance with the Royal College of Radiologists (RCR) guidance. These meetings facilitated collective learning from radiology discrepancies and errors that enhanced patient safety. Learning points from these meetings were shared with staff and referrers as appropriate.
- Radiologists held regular peer review meetings of caseloads across all modalities, to which the superintendent radiographer was invited. Feedback on these meetings was disseminated to all radiography staff in 'learning meetings'.
- A recent patient dose audit was carried out by the medical physics expert (MPE) as required under the Ionising Radiation (medical exposure) Regulations (IR(ME)R) 2017. Diagnostic reference levels are required under IR(ME)R as part of dose optimisation to ensure that patient doses are kept as low as reasonably achievable. This dose audit showed up to date local diagnostic reference levels. They evidenced that the provider's patient diagnostic reference levels were better than the national average.
- Staff doses were monitored as required under the Ionising Radiation Regulations 2017. Staff radiation monitors were analysed monthly and were below the annual constraint for non-classified workers. CT radiographers did not wear film badges and this was risk assessed by the radiation protection advisor and the medical physics expert.
- There was a quality improvement team which promoted and implemented quality improvement practice. This team communicated outcomes, strategies and action plans to staff through staff meetings and quality improvement afternoon sessions which were held quarterly and all staff were expected to attend. Clinics were suspended to facilitate maximum attendance.
- There was 10% external audit of all PET-CT reporting. We saw the provider did regular audits of patient comments cards (Friends & Family Test); urgent & unexpected clinical findings pathway; lost scanning time; unused appointments; infection control, incident reporting, staff survey & SLA breach data.

Nutrition and hydration

- There was a water fountain situated in the patient waiting area. Patients were provided with hot drinks and a biscuit following a procedure. There were cafes within the main hospital which staff could direct or escort patients to.
- Patients who needed to fast before their scan were given information about this in advance.

Pain relief

- Patients told us they were offered pain relief at regular intervals and we heard staff regularly ask patients about their pain comfort levels. There was a patient group directive in place for radiographers to administer simple pain relieving medicine.

Diagnostic imaging

Patient outcomes

- The provider was accredited with UKAS Imaging Services Accreditation Standard (ISAS), 2017-2021. Imaging Services Accreditation Scheme (ISAS) auditors carry out checks on the quality of the service provided and instigate continuous improvements to ensure patients receive a high- quality service. The Paul Strickland Scanner Centre was assessed between November 2017 and January 2018 and auditors found it continued to demonstrate its competence and conformed to the ISAS standard. The areas of scope included computerised tomography; magnetic resonance imaging; radionuclide imaging (PET-CT); picture archiving and communication system (PACS) and teleradiology.
- Reporting guidelines and procedures were in place and there was an image quality feedback mechanism which monitored the quality of imaging procedures. This ensured images were of optimal diagnostic quality according to current best practice.
- The service worked collaboratively with colleagues to agree and deliver appropriate imaging pathways to ensure diagnosis within specified timescales with minimised delays for patients. All images were reported in accordance with agreed local practice by competent staff to deliver accurate and effective radiological and clinical interpretation of images.
- Ten per cent of each reporting consultant's work was randomly selected for the PET-CT audit. Scans which confirmed new diagnoses of cancer were reviewed at multidisciplinary team meetings; these equated to 2% of all CT and MRI images.
- Images sent to outsourced reporting were subject to an additional 10% audit to ensure quality of reports. This outsourced external reporting was CT and MRI only.
- The majority of imaging undertaken was follow-up, staging and response to treatment and was reviewed jointly by an oncologist and radiologist in clinical discussions for decision-making.
- There were learning/discrepancy meetings every two month which radiologists and radiographers attended and a report was made to board.

- There was a system of instant messaging between radiologists and radiographer which contributed to ongoing feedback and improvements in image quality.

Competent staff

- There was a clinical supervision and competencies policy, training and development policy, statutory and mandatory training programme and appraisal process in place to support staff. Staff told us they were supported to do additional external and internal training in particular areas to enhance their skill set.
- Professional registration checks were made by the NHS trust. Medical staff revalidated every five years and records were kept by the provider as well as the NHS trust for assurance purposes.
- We saw documentary evidence to show there was 100% appraisal rate for all staff.
- Radiographers had individual competency checklists which recorded training and competency assessments for each of the imaging modalities. These were reviewed by radiographer & superintendent at the start of a new clinical rotation, at appraisal and at the six-month review to address any training and supervision requirements. Records of individual continuous professional development were maintained and reviewed by line managers.
- Radiography assistants told us they were supported to expand their role that included weighing and measuring patients and administering x-ray contrast medium. They attended training and maintained a link between the waiting patient and the radiographer or radiologist.
- The staff core was flexible and all radiographers, other than superintendents, rotated across the modalities.
- There were four study afternoons per year, each focussed on different topics. These included patient safety, patient experience, bullying and harassment and business continuity planning rehearsal. All staff were encouraged to attend and clinics were suspended on these days.
- Staff learning and development was encouraged with external consultants invited to work with staff on action learning.

Diagnostic imaging

- We saw that non-medical referrers were approved by the medical physics expert, who confirmed they had the relevant training and competency to refer patients to the service.

Multidisciplinary working

- The Paul Strickland Scanner Centre had good working relationships with the referring NHS trusts as well as with other external referrers.
- Radiologists and oncologists from the nearby cancer centre visited the Paul Strickland Scanner Centre regularly and we observed one such multidisciplinary meeting. The purpose of this was to review images and consider any unexpected or significant findings.
- Radiographers and radiologists met on a regular basis to review patients. Radiographers told us there was good interaction with nursing staff from the local NHS hospital that enhanced patient handover.
- The service had a contract in place for the provision and interpreting of x-ray reports from a private radiology reporting service.

Seven-day services

- The centre was operational from 7.30am to 6.30pm Monday to Friday. Additional MRI and PET CT clinics were run on a Saturday between 8.00am and 5.00pm, subject to demand.
- The Pharmacy service within the NHS hospital was available 52 weeks of the year, Monday to Friday (excluding Bank Holidays) between 9:00am and 5:00pm. Pharmacy also provided a service out of the normal hours as required.

Health promotion

- Information leaflets about the type of scan they would have were sent to patients with their appointment letters and were available in the waiting rooms. These leaflets included information about what the scan would entail and what was expected of the patient before and after the scan appointment.
- Health promotion information leaflets and posters on subjects such as smoking cessation services and information on living with cancer were on display in

the waiting rooms. In addition, there was a range of information leaflets for patients and relatives, including those from Macmillan Cancer Support which patients could take away.

Consent and Mental Capacity Act

- All staff we spoke with understood the requirements of the Mental Capacity Act 2005 (MCA).
- Patients completed a MRI safety consent checklist form which recorded the patients' consent and answers to the safety screening questions. This was scanned onto the electronic system and kept with the patients' electronic records.
- A consent policy written in line with national guidance was available to all staff. We reviewed four patient care records and saw they included record of consent to treatment. In addition to this, we observed staff obtaining verbal consent from the patients during their treatment and gave assurance that the process could be suspended at any time.
- They understood the need for consent and gave patients the option of withdrawing consent and stopping their scan at any time. Records we reviewed showed that patients consented to the procedure.
- During this inspection there were no patients who lacked capacity to make decisions in relation to consenting to treatment. Staff also told us they encouraged patients to be accompanied where there were concerns about their capacity to consent to care or treatment.

Are diagnostic imaging services caring?

Good 

We previously did not have the authority to rate this service. However, on this inspection we did have the power to rate and we rated caring as good.

Compassionate care

- The provider carried out an annual patient satisfaction survey; the results for the 2017 survey were based on responses gathered from up to 250 comment cards completed by patients each month. These were

Diagnostic imaging

analysed by the clinical leads and improvements made in response to the feedback. They were also shared with staff and the board of trustees for information, discussion and action.

- Friends and Family Test (FFT) related questions in the survey showed that 100% of all respondents were extremely likely or likely to recommend the Paul Strickland Scanner Centre to their friends or family for all modalities.
- Staff treated patients with dignity, kindness, compassion, courtesy and respect. Staff introduced themselves prior to the start of a patient's treatment, explained their role and what the patient was likely to experience during their appointment.
- We saw staff interacted well with patients and included them in general conversation. Many patients were known to members of staff and we heard staff asking them how they had been since their last appointment.
- Feedback provided by patients demonstrated that patients found staff to have a kind and caring attitude. Patients we spoke with said "I have nothing but praise for everyone in this centre" and "Staff recognise that I am frightened which is such a relief because when I am with my family, I have to pretend that I am taking it all in my stride."
- The provider had a chaperone policy which stated that patients with communications needs, including those with a learning difficulty or those who did not speak, must have formal chaperone support. We met staff trained in how to chaperone during inspection. They told us they were available to chaperone any patient who requested this.

Emotional support

- We were told that patients known to be nervous were often given a double appointment to offer assurance and show them how the scanning machines worked. Throughout inspection, we saw staff offer reassurance to patients and their relatives. They stopped to chat as they passed through the waiting area and made sure they were comfortable.
- Patients were involved in the development of a video for people having an MRI scan and with the development of patient information literature.

- There were information leaflets for each modality that were sent to patients in advance of their appointment; these leaflets were also available in the reception area. They clearly explained what each scan involved; as well as any preparation that the patient was required to make.

Understanding and involvement of patients and those close to them

- The service provided clear, relevant and up-to-date information regarding the service. This explained the purpose and nature of planned procedures which enabled patients to make informed decisions about their care, reduce their anxiety and give them confidence in their examination.
- Patients we spoke with told us they were included in discussions about their treatment plan. They said, "I have had a full discussion about the different treatment options; ultimately I am happy to go with their advice as I know I couldn't be in better hands."
- We saw that a family member was invited to remain with their elderly relative during their scan. They were instructed on safety measures and both patient and relative were offered assurances by the radiographer throughout the procedure.

Are diagnostic imaging services responsive?

Good 

We previously did not have the authority to rate this service. However, on this inspection we did have the power to rate and we rated responsive as good.

Service delivery to meet the needs of local people

- The service was planned and designed to meet the needs of the patients. Information about the needs of the local population and the planning and delivery of services was agreed collaboratively with the referring NHS trusts and the service. The unit provided services through a contractual agreement with the referring trusts.
- Progress in delivering services against the contractual agreement was monitored by the referring NHS trusts

Diagnostic imaging

and the service through key performance indicators, regular contract review meetings, and measurement of quality outcomes including patient experience. Performance was reviewed and service improvements agreed at these meetings.

- The service provided weekday evening appointments to accommodate the needs of patients who were unable to attend during daytime hours. It was all on ground floor level and was accessible to all patients. We saw patients in wheelchairs could access all areas of the centre easily.
- Two buses serviced the hospital where the Paul Strickland Scanner Centre was located. There were car parks which patients could also use.
- The provider had a learning disability champion, two dementia champions & an accessible information lead. Staff told us these champions provided support and information and were very responsive to queries.
- The appointments team called all patients due for MRI and PET-CT scans to make an appointment and to explain the procedure. This gave patients the opportunity to ask questions and if necessary, to speak with a radiographer at that time.
- Each telephone call was followed up by an appointment letter or email, which provided details of how to prepare for the scan and patients were encouraged to contact the unit if they had any concerns or questions about the impending examination.
- The 2017 patient satisfaction survey showed 100% satisfaction with appointment date and time for CT; PET-CT and MRI. Patients told us they found that appointments were at their convenience rather than that of the staff.
- Staff acknowledged that the waiting area was compact. It was busy at various times during our inspection day. Patients sat in close proximity to each other; however, there was sufficient seating.
- The provider was in discussion with the local NHS trust about the renewal of their lease. Once this was renewed, building works could begin. These included increased patient seating, additional changing areas and toilets, a private consultation office and improved office and staff areas.

Meeting people's individual needs

- Many patients who attended the Paul Strickland Scanner Centre were frail and elderly with additional issues which included mobility restrictions, mental health or dementia. In order to be able to offer maximum support, staff were trained in communication skills; conflict resolution and equality and diversity. There were two members of staff who were dementia champions which was in recognition of the high volume of elderly patients who attended the clinic.
- Mobility aids including wheelchairs and walking frames were available to support patients with physical needs. Booking procedures ensured patients who required extra time and support were accommodated. There was a variety of ways in which this happened; for example, appointment times could be extended; booked at the beginning or end of the day and the patient could be invited in to see what the scanning machines looked like and be talked through the expected process.
- We saw there were guidelines for the safe transfer of care and clinical handover of in-patients, outpatients and where the patient travelled on hospital transport. There was no nursing support in the centre and so any in-patient transfer had to have a suitably trained healthcare professional to attend to their medical needs whilst on site.
- The MRI scanner which was installed in June 2018 had a bigger bore which meant that patients did not feel so enclosed. Music was provided and radiography staff talked to patients to allay their fear when in the scanner. A friend or relative could accompany patients, including those with learning difficulties or dementia.
- The quality improvement team engaged with patients to ensure information was accessible, clear and available in formats tailored to individuals and their carers. Information included written text sent by email and post; there was also information on the PSSC website and on social media.
- The provider accessed a telephone interpreting service for patients who did not use English as their first language and used a list of local interpreters.

Diagnostic imaging

- Patients could request preferred appointment times and multiple procedures were co-ordinated on same day, including appointments at the on-site NHS hospital
- The provider's 'did not attend' rates were negligible; this was in part due to patients being sent a text message reminder the day before their appointment. The registered manager told us that the main reason for patients not attending was because they were too sick to attend.
- We were told how the workload increased in the past year in PET-CT and the service introduced some extended day working in response to this.
- There was a patient notice board in the waiting area that informed patients of key staff and how to contact them. We were told there was access to a translation service where English was not the patient's first language. We saw there was a folder for people with communication needs. This included signs and symbols for patients with a learning difficulty, as well as for patients with a hearing impairment.
- Patients who attended the centre on a regular basis told us they always received their results very quickly. Results were always available by the time they attended the outpatient department of the local NHS hospital.

Access and flow

- Patients had timely access to scanning. Capacity was adjusted in response to unexpected fluctuations in demand. The provider extended the working day at times when demand exceeded capacity in order to meet the demand and additional MRI clinics were run on Saturdays.
- The provider had a contract with the NHS trust for patients on a two-week cancer pathway. The standard was that 100% of scans should be completed within two weeks of referral date. Submitted data showed this was achieved 92% of the time for MRI and 100% for CT.
- Where several clinically urgent requests were received, advice was sought from a radiologist on the priority order for booking. Radiologists categorised referrals based on clinical urgency to ensure imaging was performed in a timely manner to reflect the urgency of the request.
- All referrals were reviewed prior to an appointment being made. Computerised tomography radiographers reviewed forms and a radiologist justified each request. Trained radiographers in MRI were responsible for vetting and assigning protocols. Operators in PET-CT authorised routine referrals by protocol.
- Staff told us there were systems in place to accommodate urgent referrals. There were two urgent MRI and four CT slots set aside every day which were not bookable for any other patient until one hour before the slot start time. There were protected slots for urgent cardiac and gynaecology consultations that required a multidisciplinary team approach.
- Any additional emergency patient was either scanned at the end of the day or accommodated within the scheduled list. We saw a sample of clinic schedules which included pre-designated emergency patient slots. A standby list was kept where these patients would be offered an appointment cancelled by another patient.
- There were no urgent PET-CT appointments as the tracer was ordered specific to the patient the day before an appointment is due. The required patient preparation for a PET scan included six hours pre-scan fasting. There were up to three slots per day reserved for next day appointments Monday to Thursday and five rapid access slots for Friday which were booked on Thursday.
- At times when the service experienced interruption, patients were prioritised according to surgery date, multidisciplinary team date, clinic date, cancer pathway timelines, breach dates and clinical urgency determined as part of vetting procedures.
- We saw that September 2018 board minutes noted there was 13.2% downtime in August which included breakdown of the volume computed tomography scanner. These minutes recorded that no patient pathway was affected by the disruption to service as staff worked long days and additional weekend lists were provided in August.

Diagnostic imaging

- The provider cancelled 237 procedures between October 2017 and September 2018 (1.3%). The main reason for cancellation cited was scanner breakdown. We discussed this with the operations manager and the registered manager. They told us that prior to cancellation, a radiologist did a risk assessment to ensure patient safety was not compromised.
- The operations manager reviewed the list of unreported examinations on a daily basis. Waiting and reporting times are also reviewed at weekly leadership team meetings. The service outsourced a proportion of CT and MRI scans to an independent reporting agency.
- The provider had a 95% standard that reports should be approved by a radiologist within three days of scans completion. These results were discussed at board level and there was agreement that the audit would be repeated each month to monitor progress in performance.
- We saw data which demonstrated there was between 92% and 100% compliance with the contract requirement of the two-week pathway (from request received to scan completed date). The provider's performance was 94% against the standard of 95% for urgent scans to authorised data and result.

Learning from complaints and concerns

- There was a compliments, complaints and concerns leaflet in the waiting area which explained how patients could provide feedback. It also signposted to patient advice and liaison service (PALS) and other organisations.
- Patients were advised about how to make a formal complaint and given a patient information leaflet 'Comments, compliments, concerns & complaints'. This was also available in the reception area and included how to raise concerns or a formal complaint as well as information on the Parliamentary & Health Service Ombudsman and patient advocacy services.
- The provider received two formal complaints between October 2017 and September 2018, both of which were managed through the formal complaints procedure. We saw they were dealt with in a timely manner and neither was upheld.

- Verbal complaints were resolved as soon as possible by the person receiving the complaint or by a person with the necessary authority or expertise. The registered manager was informed of all complaints.
- The provider received 496 compliments between October 2017 and September 2018.

Are diagnostic imaging services well-led?

Good 

We previously did not have the authority to rate this service. However, on this inspection we did have the power to rate and we rated it as good.

Leadership

- The service was led by a registered manager, an operations manager and a professional development lead superintendent. The leadership team worked with the board of trustees to deliver agreed strategy and objectives.
- The registered manager was an experienced and competent chartered physiotherapist, registered with the Health and Care Professionals Council. They were capable and knowledgeable in leading the service. They were enthusiastic and were keen to improve the quality and service provided.
- The registered manager was visible and approachable. Staff spoke positively about them and told us that the manager was supportive of them and mindful of staff welfare.
- There was recent leadership training programme for senior managers. Staff agreed on a set of seven leadership attributes and a staff recognition scheme to reward those who exemplify the leadership attributes.

Vision and strategy

- The provider values reflected the values of the local NHS trust of putting patients first; continuous improvement; value everybody; open and honest and work as a team (PIVOT).

Diagnostic imaging

- The provider's aim was to provide the highest quality service for patients and to have the best equipment. It was to foster innovation and support research and to ensure that staff felt valued.
- The additional vision held for patients included world class scanning; clinical excellence; innovative research and to enable early diagnosis and treatment monitoring.
- Staff learnt of the core values at their induction and could tell us about them. They expressed full commitment to this vision and were proud to be part of the organisation.
- Formal team meetings were held monthly and minutes were taken at these meetings. Each modality held a weekly team meeting. We saw minutes from a sample of meetings which included; rotas, incident reporting and key performance indicators.
- Staff told us there were good opportunities for continuing professional development (CPD) and personal development in the organisation. They also stated they were supported to pursue development opportunities that were relevant to the service.
- Equality and diversity was promoted within the service and was part of mandatory training. Inclusive, non-discriminatory practices were promoted. A whistle blowing policy and duty of candour policy, as well as access to a 'speak in confidence' service supported staff to be open and honest. Staff could describe to us the principles of duty of candour.
- All independent healthcare organisations with NHS contracts worth £200,000 or more are contractually obliged to take part in the Workforce Race Equality Standard (WRES). Providers must independently collect, report, monitor and publish their WRES data and act where needed to improve their workforce race equality. However, the provider told us they did not collect, report or monitor WRES data in accordance with their contractual obligation.

Culture

- Each member of staff we spoke with was very positive and happy in their role. They told us they were proud to be associated with the service which they felt was at the forefront of safe, high quality and innovative practice.
- There was a staff wellbeing champion and staff had access to 'Speak in Confidence' service to report concerns as well as the local trust employee relations advisory service.
- Staff reported they felt supported, respected and valued. They said they were actively encouraged to make suggestions and contribute to changes and improvements in the service.
- We found the staff demonstrated pride and positivity in their work and the service they delivered to patients and their service partners. They told us they had sufficient time to support patients, and described a positive teamwork approach.
- There was a positive approach to reporting incidents and we saw evidence during the inspection that outcomes and changes were implemented in response to incidents. Staff told us there as a 'no blame' culture.
- Staff told us there was good communication between everyone in the service. This was in multiple ways including informal chats, team meetings, and emails. There was also information sharing during quality improvement afternoons and learning meetings.

Governance

- The registered manager had lead responsibility for clinical governance at the Centre. There were governance frameworks to support the delivery of good quality care. The service undertook several quality audits, and information from these assisted in driving improvement and giving all staff ownership of things had gone well and action plans identified how to address things needed to be improved.
- Local governance processes were achieved through team meetings and local analysis of performance, discussion of local incidents. Regular meetings were held and recorded for each area of the service; for example, weekly leadership team meetings, monthly (PACS) and information technology, as well as quarterly research and development meetings. Radiation safety group meetings were held twice a year.

Diagnostic imaging

- Feedback and actions from performance discussion of local incidents were fed into processes at a corporate level. We saw evidence of this process in meeting minutes and meeting notes during our inspection.
 - Different groups were established to drive up performance and improve patient experience. These included a quality improvement team, staff engagement team, safety team, clinical audit team and service improvement groups for each modality. There were 'Hits & Misses' meetings which were held quarterly across modalities and gave radiologists an opportunity to discuss challenging or unusual cases and any missed findings, with learning points fed back to staff and referrers as appropriate.
 - Staff were clear about their roles and understood what they were accountable for. All clinical staff were professionally accountable for the service and care that was delivered within the unit.
 - Procedures for information governance and clinical records management followed best practice. The provider had data sharing agreements in place with all image exchange portal (IEP) recipients. No new recipients were added without this data sharing agreement being signed. In addition, the provider's core information technology and information governance policy outlined the regulations and provided the correct reporting pathway to the information commissioner's office and the individual where there was a breach of personal data.
 - Working arrangements with partners and third-party providers were managed. For example, there was service level agreement between the service and the local acute trust. Monthly quality reports were issued and regular meetings were held to discuss the service provided.
 - The provider had a business continuity plan to prepare PSSC for potential continuity incidents. For example, if there were extended service interruptions caused by factors beyond the control of the service.
- registered manager had continuous oversight of the risk register and reviewed it weekly with the senior leadership team. We saw that each risk had a named person against it and updates were added accordingly.
- The three top risks included PET-CT bid awaiting approval, the impending end of the current land lease from the local NHS trust and the service level agreement for provision of staff and services with the local clinical commissioning group. Staff we spoke with were aware of these risks. They told us the one most likely to impact on them was the bid approval, which would lead to additional work and necessary expansion of the team.
 - The radiation protection committee met twice each year. Radiography protection advisers reported to this committee on safety issues as well as any reportable incidents. Minutes for May 2018 highlighted there were no staff dose incidents in the six-month reporting period.
 - The safety team met monthly and focused on promoting safe practice. Members of this team included the centre's health and safety representative, Control of Substances Hazardous to Health lead and infection control lead.
 - The service did not have a back-up generator. The Board accepted this risk and we saw it was added to the risk register in 2015 and reviewed regularly since then.

Managing information

- An IT security and governance group was established which ensured that the data protection regulations (GDPR) were implemented as required by May 2018.
- The service was aware of the requirements of managing a patient's personal information in accordance with relevant legislation and regulations. General Data Protection Regulations (GDPR) had been reviewed to ensure the service was operating within the regulations.
- Staff viewed breaches of patient personal information as a serious incident and would therefore manage this as a serious incident and escalate to the appropriate bodies, including the information commissioner's office.

Managing risks, issues and performance

- The risk register was overseen by the Board of Trustees, and an audit and risk committee which met three times a year. All risk assessments were kept electronically within the central document library. The

Diagnostic imaging

- There were sufficient computers in the unit for the number of staff to be able to access the system when they needed to.
- All staff we spoke with demonstrated they could locate and access relevant and key records very easily and this enabled them to carry out their day-to-day roles.
- Electronic patient records easily were accessed but were kept secure to prevent unauthorised access to data.

Engagement

- Patient satisfaction cards were given to all those who had been scanned in the centre to gain feedback on the service received. This generated a large volume of feedback that was overwhelmingly positive.
- In response to comments from patients, appointment letters were revised and new patient information leaflets were designed for each modality. There was a redesigned leaflet which included information on parking and transport as a direct response to patient comments on areas for improvement. Other actions taken by the provider in response to comments included issuing patients with blankets since scanning rooms were usually cool to prevent machinery from overheating.
- A patient group was established and consulted with via e-mail about prospective service changes and ongoing modifications.
- There was patient input to all information booklets; for example, the information sent to patients for each modality.
- There was active staff engagement with service redesigns and improvements which encouraged commitment and fostered a sense of ownership of service developments. There was a cross departmental committee which promoted internal communication, staff engagement and acted as a bridge between senior management and other staff. Staff told us that whilst there were no barriers to communication with senior management, this committee was efficient in relaying information between staff and management.
- The most recent annual staff survey showed that overall staff felt well supported by their line manager.
- The service had a good relationship with the host hospital NHS trust and engaged regularly to understand the service they required and how services might be improved. This produced an effective pathway for patients.
- The annual referrer's survey obtained feedback to inform strategic planning and service development. This gave suggestions to improve information technology which included an integrated electronic referral system and improved ways in which patients' images were viewed remotely. The provider submitted an extract of board meeting minutes following this inspection which showed that the budget for these improvements was agreed.

Learning, continuous improvement and innovation

- The provider received a Pharmaceutical Industry Networking Group life science innovation award in July 2018. This was awarded in recognition of work and innovation surrounding whole body MRI imaging for cancer.
- Radiographers were awarded first prize for their e-poster 'Advancing care of patients with dementia during PET-CT imaging' in 2017 by the UK Radiology Conference (UKRC).
- Three members of staff had their poster on improving patient experience through ongoing feedback accepted for presentation at both UKRC and the European Congress of Radiology.
- The Paul Strickland Scanner Centre was also a research centre and was involved in many clinical trials to help find new treatments and encourage changes in practice. Research included innovative chemotherapy and immunotherapy treatment.
- There were modality-based service improvement groups whose role it was to initiate change within each scanning modality.
- A new MRI scanner was installed in June 2018, which was a joint venture between the Paul Strickland Scanner Centre and Mount Vernon hospital cancer centre. The expectation was that this collaboration will enhance patient outcomes.

Diagnostic imaging

- The provider had a career development structure for radiography assistants which was part of a staff development and retention programme.

Outstanding practice and areas for improvement

Outstanding practice

- The service had an active research and development programme some of which included PET-CT in head and neck cancer; whole body scanning in breast cancer and dose optimisation.

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should ensure that there is a formal audit process for 'pause and check'.
- The provider should ensure that the resuscitation equipment is checked each day the clinic is operational.
- The provider should ensure that there is a clear system of contrast agent stock rotation.
- The provider should fulfil their responsibilities under the Workforce Race Equality Standard.

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.

This section is primarily information for the provider

Enforcement actions

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.