

Wigan PET Centre

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Wigan PET Centre is operated by Alliance Medical Ltd. The centre opened in September 2016 and has diagnostic imaging facilities for positron emission tomography and computed tomography scans for adults under a commissioned contract from a specialist NHS trust. Patients are booked by the referring trust, then scans are reported by the consultant radiologists at the trust.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced inspection on 11 December 2018.

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.

Services we rate

We rated it as **Good** overall.

We found good practice about diagnostic imaging:

- The service provided mandatory training, including safeguarding, as well as service-specific competency training to all staff and made sure everyone completed it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. Premises and equipment were suitable and well maintained.
- The service had enough radiography staff with the right qualifications, skills, training and experience to keep people safe to provide the right care.
- Staff kept records of patients' care. Records completed by staff were clear and completed appropriately. Radiopharmaceutical medicines were stored and administered in line with best practice.
- The service managed incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned across the organisation.
- The service provided care and treatment based on national guidance. Managers checked to make sure staff followed guidance.
- Staff worked together as a team to benefit patients. Radiographers were supported by the NHS trusts to provide good care.
- Staff understood their roles and responsibilities under the Mental Capacity Act 2005.
- Staff cared for patients with compassion. Patients' feedback showed that staff treated them well with respect and kindness. Staff put patients at ease and explained procedures in a way that patients and those close to them understood.
- The service took account of patients' individual needs.
- The service treated concerns and complaints seriously. Lessons learned were shared across the organisation.
- Managers had the right skills and abilities to run a service providing high-quality care. They promoted a positive culture that supported and valued staff.
- The service and organisation had governance systems in place, including identify and managing risks.
- The service involved patients and staff well.

We found areas of practice that require improvement:

- Referrals into the service were not always clear and the service needed to confirm the details.

Summary of findings

- Appointments were made by the referring NHS trust by letter only. Patients did not always attend for appointments as there was no system to confirm attendance.
- Difficulties with insufficient supplies of the radiopharmaceutical doses, affecting all contracted services, had resulted in cancellations of patients on the day of the appointment.
- There was no information or leaflets available in formats such as easy read or in languages other than English.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve.

Ellen Armistead
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Diagnostic imaging

Rating Summary of each main service

Good



Wigan PET Centre provides both positron emission tomography and computed tomography scans for NHS adult patients. The service provides scans for patients from across the north west. It is commissioned by a specialist NHS trust. In the twelve months before inspection, 2988 scans were carried out. We found that there was sufficient staff that were trained, skilled and competent to provide the service. The centre was visibly clean and equipment was well-maintained. Staff delivered care in line with best practice together with the neighbouring NHS trust and the referring specialist NHS trust. Patients were positive about care received and we observed patients put at their ease. Patients were treated as individuals and staff supported those with additional needs. Written information was available, however; not in a format other than English. Managers supported staff in an open culture. Organisational governance and risk processes were in place with information shared with staff. Appointments were made by the referring hospital and results of scans were shared, by them, with patients.

Summary of findings

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Good 

Wigan PET Centre

Services we looked at

Diagnostic imaging

Summary of this inspection

Background to Wigan PET Centre

Wigan PET Centre is operated by Alliance Medical Ltd. The service opened in 2016. It is a positron emission tomography and computed tomography scan service in the grounds of the NHS trust hospital in Wigan, Greater Manchester. The service provides diagnostic services for referrals from a specialist trust in Manchester.

The hospital has had a registered manager in post since 2016. At the time of the inspection, plans were in progress for the unit manager to take over as CQC registered manager, although both were available when inspected.

Our inspection team

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

Information about Wigan PET Centre

The service is registered to provide the following regulated activities:

- Diagnostic and screening procedures.

During the inspection we spoke with seven staff including radiographers, a clinical assistant, bookings co-ordinator, student radiographer and managers. We observed patients receiving care, spoke with two patients and one relative. During our inspection, we reviewed 10 sets of patient records.

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

Activity

- Between December 2017 and November 2018, there were 2,988 attendances recorded that were all NHS funded.

Track record on safety

Between September 2017 to August 2018

- There were no never events or serious incidents.

- There were no incidences of hospital acquired Meticillin-resistant staphylococcus aureus (MRSA).
- There were no incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA).
- There were no incidences of hospital acquired Clostridium difficile (C.difficile).
- There were no incidences of hospital acquired E-Coli.
- There were no complaints.

Between February 2017 and November 2018, there were 34 incidents that were all classified as no harm.

Provider services accredited by a national body:

- ISAS July 2018 to July 2021
- ISO27001 June 2018 to June 2021

Services provided at the hospital under service level agreement:

- Cleaning services (internal facility only)
- Building maintenance (infrastructure only)
- Portering (patient transfers / post / waste removal / deliveries of consumables)
- Linen services
- Waste management
- Staff car parking and security
- Telephone usage
- IT first response help desk

Summary of this inspection

- Resuscitation Services
- Fire safety & fire safety equipment (including training)
- Utilities
- Infection control and prevention
- Transport
- Catering

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?

Are services safe?

Good



We rated it as **Good** because:

- The organisation provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff had safeguarding training on how to recognise and report abuse and they knew how to apply it. Staff at the service worked with the neighbouring trust to protect vulnerable patients.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean.
- The service had suitable premises and equipment and looked after them well.
- The service had enough staff with the right qualifications, skills, training and experience to provide the right care.
- Staff kept records of patients' care. Records at the centre were clear and completed well.
- The service followed best practice when storing and administering medicines. Patients received a radiopharmaceutical before scanning. (Aradiopharmaceutical is a drug that can be used either for diagnostic or therapeutic purposes and is radioactive).
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Incidents across the organisation were shared, by managers at the centre.

However:

- Records from the referring NHS trust were provided daily, but information was not always clear. This meant the service needed to confirm the details with the referring trust.

Are services effective?

Are services effective?

We do not rate the effective domain in diagnostic services.

- The service provided care and treatment based on national guidance. Managers checked to make sure staff followed guidance.
- Staff monitored patients regularly to check if they were in any pain.

Summary of this inspection

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held meetings with them to provide support.
- Staff worked together as a team to benefit patients. Radiographers and clinical assistants were supported by the neighbouring and referring trust to provide good care.
- Staff understood their roles and responsibilities under Mental Capacity Act 2005. They knew how to support patients who lacked the capacity to make decisions about their care.

Are services caring?

Are services caring?

We rated it as **Good** because:

- Staff cared for patients with compassion. Feedback from patients, verbally and in the organisations patient satisfaction survey was overwhelmingly positive and confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress. We observed interactions between staff and patients. Staff put patients at their ease whilst delivering care.
- Staff involved patients and those close to them in decisions about their care and treatment. Staff explained procedures to patients in a clear way. Patients could attend with friends or relatives if preferred and were involved.

Good



Are services responsive?

Are services responsive?

We rated it as **Good** because:

- The service delivered care as planned by the referring NHS trust
- The service took account of patients' individual needs. The centre was accessible for patients with reduced mobility and a hearing loop was present.
- Interpreters could be accessed for patients whose first language was not English.
- The service had not received any complaints although information was available for patients if needed. The organisation shared any lessons learned from any other complaints received with the staff at the centre.

However:

- Appointments were made by the referring NHS trust by letter only which meant patients may not always attend. Patients attended from a wide area of the Northwest.

Good



Summary of this inspection

- Issues, in the three months before inspection, with receiving sufficient supplies of radiopharmaceutical doses has resulted in cancellations of patient scans.
- There was no information or leaflets available in formats such as easy read or in languages other than English.

Are services well-led?

We rated it as **Good** because:

- Managers at the centre had the right skills and abilities to run a service providing high-quality care.
- Managers promoted a positive and open culture that supported and valued staff.
- Governance processes were in place for the organisation that were shared with staff as needed.
- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The service managed and used information to support its activities. It used secure electronic systems for the organisation and communication with the referring NHS trust, with security safeguards.
- The service involved patients and staff and worked with partner organisations effectively.
- The service was committed to improving services by learning from when things went well or wrong.






However:

- The organisation had embedded values, but there was no current vision and strategy. There were plans for these to be launched in January 2019.
- The contract with the referring trust did not include out of hours support arrangements.

Good



Diagnostic imaging

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

Are diagnostic imaging services safe?

Good 

Mandatory training

Staff received training in areas relevant to their role, such as health and safety, equality and diversity, information governance, moving and handling and resuscitation.

Mandatory training was delivered using a mixture of face-to-face training and e-learning.

Compliance targets for training was 100% with staff reminded 60 days before their renewal date to book an update course.

Safeguarding

There were no safeguarding incidents reported to the Care Quality Commission between August 2017 and July 2018.

Safeguarding leads were available locally and regionally for support for adults and children. The organisation's child safeguarding lead (level four trained) reported to the medical director.

Organisational policies included a chaperone policy, safeguarding adults and safeguarding children and young persons policies. The legislation "working together to safeguard children" was referenced, as well as female genital mutilation, child sexual exploitation and Prevent. A flow chart of how to escalate a concern was included in the policies. Safeguarding contact information was clearly displayed for staff.

Staff we spoke with were aware of their roles and responsibilities in safeguarding and knew how to raise matters of concern appropriately. Staff told us that they would contact the neighbouring trust's safeguarding team if a concern was identified to share the information. Between February 2017 and November 2018, there was one safeguarding incident reported on the organisation's electronic system. This was discussed during the inspection. Staff explained how they talked to the neighbouring trust safeguarding team at the time of the incident although they were already aware of the patient. This included feedback from the safeguarding team about the patient.

Mandatory training included safeguarding training. There was 100% compliance with safeguarding training. The provider confirmed, following the inspection, that all clinical staff were trained to level two and non-clinical to level one for adults and children.

Cleanliness, infection control and hygiene

There was no methicillin-resistant *Staphylococcus aureus* methicillin-sensitive *Staphylococcus aureus*, *Clostridium difficile* or *Escherichia coli* reported by the service between August 2017 and July 2018.

The waiting area, patient uptake room cubicles and examination areas were visibly clean and well organised.

Personal protective equipment was readily available and included gloves and aprons. Posters displaying 'hand sanitizing techniques' were displayed throughout the centre.

Diagnostic imaging

Wall-mounted hand gel sanitizers were readily available in all areas. Staff we observed used sanitizing hand gels before providing patient care. All staff we observed adhered to the 'arms bare below the elbows' policy in clinical areas.

There was a dedicated 'hot toilet' that was allocated for patients who had received the radio pharmaceutical. This had clear signs for patients and relatives.

Daily cleaning schedules were in place and clearly displayed. There was also domestic cleaning that took place on Sundays when the centre was closed. All privacy curtains included dates when last changed that were all recent. Curtains had printed instructions not to enter the uptake room cubicles.

Sharps bins were present, including dedicated bins to collect radioactive sharp waste; all were dated, secure and not over filled. Radioactive waste including sharps and linen were stored at the centre for three days before being disposed of via the trust's systems. This system was in place to ensure that radioactivity had gone.

Staff told us and provided examples, that if a patient presented with a communicable disease this was discussed with infection prevention and control staff at the trust. If necessary, the patient could be allocated at the end of the clinic list. A deep clean of the room would take place following the consultation or treatment.

The patient satisfaction survey included a question about how satisfied patients were with the cleanliness and appearance of the centre. Between April 2018 and November 2018, 100% of patients rated cleanliness as either satisfied or very satisfied.

Infection control was included in mandatory training for staff. From the annual infection prevention and control audit report from July 2018, the centre scored 96%. Hand hygiene compliance was 100% as well as compliance for insertion of peripheral vascular devices. The annual infection prevention and control audit target for 2017 to 18 was 80%. The service was inspected in February 2018 and scored 96%. The 2018-19 target was set at 90%. The next annual inspection is planned for February 2019.

Environment and equipment

The service was located in a purpose built modular build that was located in the grounds of the NHS trust and close to the main car park.

Staff and patients accessed the main entrance into the waiting area that included an accessible toilet for public use. All other areas were restricted to staff access only. These areas included an office, staff rest room, control room, three uptake room cubicles, examination room, a 'hot lab' (where the radiopharmaceuticals were stored and dispensed), a 'hot toilet' (for patients who had been administered the radiopharmaceutical) and storage areas including dedicated area for the resuscitation trolley. Fire exits were clearly marked and accessible.

Maintenance arrangements were in place to ensure that specialist equipment was serviced and maintained as needed. All equipment seen included evidence of a maintenance check within the last 12 months. The centre was supported by medical physicists at the referring specialist trust.

There were clear signs including no entry signs in controlled areas where radiation was administered. There were also 'pause and check' posters displayed for staff.

Access to clinical areas was restricted to staff with keypad locks to protect patients from entering unaccompanied. Access numbers to these were changed routinely every six months. In addition, a rubber-based key pad entry to the centre had been changed to metal to prevent unauthorised access by the wearing down of the numbers.

Staff displayed meters to monitor radiation doses. These were processed by a third party externally and results were fed back to the centre.

Emergency resuscitation equipment was available in the unit. The contents of the trolley were secured with a tag. There were daily checks carried out for items not tagged with a full weekly check of the trolley and contents. Emergency drugs were stored in the trolley as well as an additional box close to the examination room. Oxygen cylinders were stored securely, and accessible if required.

Assessing and responding to patient risk

Appointments were arranged by the referring NHS trust a week in advance in the form of a letter.

We observed reception staff confirming the identity of patients on arrival to the centre. Patients identity (name, date of birth and address) were checked before administration of any radiopharmaceuticals and confirmed before any scanning. Pause and check posters

Diagnostic imaging

were displayed for staff as a reminder to complete all checks including patient identification, correct date, dosages, no clinical reason not to proceed and secure management of scans.

Risk assessments, for the service were identified, such as for the handling of hazardous substances safely, local rules for radiation safety and accidental dropping of a radiopharmaceutical.

Patients and radiographers were required to complete a data form that included demographic information, medical history, possible pregnancy for women between 12 and 55 years. An additional form was completed if declared that there had been 10 days since the last menstrual period. The patient's height and weight were recorded to calculate the dose of radiopharmaceutical required. The form was highlighted where patients were required to complete including signature to consent to the procedure. We observed that details were checked by the radiographer and blank sections completed in conjunction with the patient. Medical history included any medicines taken routinely, any known allergies and any tubes, for medical purposes, in place. We observed that the process was clearly communicated to the patient including advice about remaining calm, after care and reporting of results.

Patients were required to have an intravenous cannula inserted to administer the radiopharmaceutical. Blood was tested for glucose levels, in line with best practice. If found to be outside the accepted range, the referring consultant was contacted to check if the scan could go ahead. We observed this whilst we were on-site and appropriate action was taken.

Staff were required to wear badges to monitor exposure to radiation; these were analysed to check that staff were safe in that environment.

Staff we spoke to knew how to escalate concerns about a deteriorating patient. There was an escalation policy in place. There were service level agreements in place with the neighbouring acute NHS trust.

The centre was located next to the emergency department of the trust. If a patient deteriorated, the trust could be contacted to request a doctor to review the patient. Alternatively, the patient could be transferred to the emergency department. The trust cardiac arrest number was displayed in all area for staff with

instructions about how to direct the resuscitation team from the NHS trust. The resuscitation trolley, and the contents were purchased from the trust so that the resus team would be familiar with equipment in the event of an emergency.

All clinical staff were required to undertake immediate life support training as part of mandatory training requirements. This was face to face training in line with provider requirements and aligned to Resus Council UK guidelines. There were plans to review the training and take part in the trust's resuscitation training. There was also a requirement that two staff, trained in immediate life support, be present at all times when patients were in the centre.

Call bells were accessible in the patient uptake room cubicles. If pressed, the staff attended promptly. Following the administration of the radiopharmaceutical, patients were required to wait for one hour for the medicine to absorb. Patients were advised to stay as still as possible to prevent absorption in to muscles. There were close circuit cameras in all areas with signs for patients to alert them that this was for safety reasons. Patients could be viewed, during the waiting period, in the uptake room cubicles.

Once in the examination room, signs, as well as a hazard barrier, indicated if the room was safe to enter. Patients were required to remove metal items such as spectacles or watches before scanning. Women were asked to remove bras, whilst in the toilet. Metal zips, on trousers were lowered, under a blanket, on the examination table. A privacy blind was in place between the examination area and the control room during this process.

Scans were transferred through the electronic system, direct to the referring trust, following each scan. The centre did not report on any scans.

The radiation protection supervisor, at the centre, was supported by a radiation protection advisor as well as the radiologists at the referring trust.

Staffing

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

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There were processes in place to ensure sufficient numbers of trained and support staff, to provide safe care and treatment.

The centre had a unit manager, four positron emission tomography radiographers, three clinical assistants and a bookings coordinator. There were no vacancies at the centre. Any shortfalls due to short-term sickness were filled with regular bank staff.

All staff were required to complete an induction at time of recruitment and have evidence of required mandatory training and competencies relevant to the scanning procedures and equipment following a safe scanning pathway. This included any temporary staff to cover any shortfalls.

Between June 2018 and August 2018, six shifts were covered with bank radiographers and 11 with bank clinical assistants.

The average rate of sickness, for the same time period was 5% for radiographers and 1% for clinical assistants.

A noticeboard, in the waiting area, displayed photos of the staff for the service.

Daily 'huddles' took place, before the first patient arrived where appointments and referrals were discussed for that day. These took place in a restricted staff area.

Medical staffing

There were no medical staff present in the centre. In the event of an emergency, a doctor was contacted from the neighbouring NHS trust.

For advice regarding scanning, radiologists and referring consultants were available by phone from the referring trust. The trust was the Administration of Radioactive Substances Advisory Committee holder. Contact details were displayed for staff from the referring trust's nuclear medicine department. An additional poster included contact details for medical staff who had agreed to be contacted during temporarily extended hours. However, this was a verbal agreement and not included in the written contract agreement. This was discussed, during the inspection, with the senior radiologist at the referring trust.

Records

Staff kept appropriate records of patients' care for screening.

Appointments were made by the referring trust and standardised referral forms received electronically. These forms were printed and checked for completion daily. Information was transferred to the locations electronic system and paper records destroyed when scanning was completed.

Staff told us that they needed to contact the referrer if forms were not completed clearly.

Staff at the service then completed the patient data form, with the patient present and these were scanned into the electronic systems.

All records were kept securely in areas restricted to access by staff only.

We reviewed the records for ten patients. These included referral forms and patient data forms. We found them to be completed appropriately.

Medicines

Medicines were managed appropriately following guidance. Radiopharmaceuticals were administered under the authorisation of the Administration of Radioactive Substances Advisory Committee license holder. This was the referring specialist NHS trust. Records were maintained for staff authorised to administer the radiopharmaceuticals.

Radiopharmaceuticals were prepared off-site and transported in bespoke carrying cases delivered by trained couriers authorised and labelled to transport. Once on-site, they were stored in the 'hot lab' that had key-pad entry. The height and weight of the patient was programmed into the specialist machine. This calculated the amount of radiopharmaceutical required for each individual patient. The medicine was dispensed in a sealed unit, administered to the patient and disposed into a dedicated sharps bin.

There were no controlled drugs in the centre. The only other medicines were the emergency drug boxes that were securely stored and intravenous fluids in the tagged resuscitation trolley.

An organisation pharmacy advisor was available if needed. Medicines management was included in mandatory training.

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Incidents

Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff reported incidents via an electronic system. Staff shared examples of incidents reported and also compliments reported on the system.

There had been no never events or serious incidents in the reporting period between September 2017 and August 2018. There were no Ionising Radiation (Medical Exposure) Regulations incidents for the same time period.

Between February 2017 and November 2018, there were 34 incidents reported, all of which were classified as no harm. Incidents included appointment issues, cancellations due to patient choice and late return of staff radiation monitoring badges.

The service investigated serious incidents using a root cause analysis approach and the manager had received training to complete. Incidents for the provider were shared throughout the organisation in monthly risk bulletins.

Staff we spoke with understood the term duty of candour. (The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.)

Are diagnostic imaging services effective?

Not sufficient evidence to rate 

Evidence-based care and treatment

The service followed best practice guidance including Administration of Radioactive Substances Advisory Committee and Ionising Radiation (Medical Exposure) Regulations.

Policies and procedures are followed both at provider level and site specific for the location. Local procedures reflect organisation policy about Ionising Radiation Regulations 2017. The Ionising Radiation Regulations are regulations concerned with the protection against exposure to ionising radiation as a result of work activities.

There was a requirement for any new policy or procedure to be read, reviewed and signed by each member of staff.

An audit schedule was in place that included monthly positron emission tomography and computed tomography dose monitoring, an annual radiation protection advisor audit, an annual infection prevention and control audit, a bi-annual policy audit, monthly reporting and image quality audits. (A radiation protection advisor audit includes an inspection by a radiation protection specialist to ensure ionising radiation is being managed safely.)

Nutrition and hydration

Patients were sent letters from the referring specialist trust with instructions about fasting before the scan. Water was encouraged in the centre to support the radiopharmaceutical uptake.

Following the scanning, patients were offered a hot drink and a biscuit before leaving the centre.

Pain relief

Staff verbally asked about any symptoms during the consent process but did not record any assessment of pain score.

If the patient was an in-patient, the national early warning score chart where patient's vital signs were monitored, included a pain score.

There were no pain relief medicines stored in the centre.

Patient outcomes

Performance was monitored monthly, within the organisation, with a focus on areas such as incidents, training compliance, patient satisfaction and complaints. Reporting of scans was completed by the referring NHS trust. The centre had a key performance indicator of

Diagnostic imaging

completing a minimum of 1,500 scans a year within seven days of referral. In 2017, 2,989 patients were scanned and, at the time of inspection, in 2018 3,426 patients had received a scan.

The radiation protection advisor report, in September 2017, showed that legislation was being adhered to and documents were up-to-date. In September 2018, a breach of the environmental permitting regulations permit was identified and updates in documentation needed to be completed. Waste operations require an environmental permit if the business uses, recycles, treats, stores or disposes of waste. A copy of the incident report was provided, which included recommendations and identified lessons learned that were shared. There were no actions outstanding.

Competent staff

All staff, at the centre had received an appraisal, as well as supervision, in the twelve months before inspection. These were based on the values of the organisation including collaboration, excellence, learning and efficiency.

Each staff member maintained a paper file of training attended including mandatory training and competencies relevant to their role. These included completing daily maintenance checks, operating the scanner and administration of the radiopharmaceuticals.

Training courses, organised by the specialist NHS trust were displayed. Staff were encouraged to book on and were supported to attend these courses.

Multidisciplinary working

Staff worked together as a team to benefit patients. Radiographers and clinical assistants supported each other to provide good care.

There was effective internal multidisciplinary team working that included centre staff and the wider organisation.

There was effective external team working. The centre was supported by staff from the neighbouring trust for tasks such as cleaning and waste disposal. In addition, the referring consultants were contactable for support, at the specialist NHS trust.

Seven-day services

The centre was routinely open Monday to Friday between 7.30am and 7.30pm. Due to equipment changes at two NHS trusts, increased demand resulted in temporary arrangements being put in place for extended hours up to 10pm on certain days as well as some Saturday appointments.

Health promotion

The centre provided a scanning service only that included routine questions in the patient data form and the well-being checks during the appointment.

Consent and Mental Capacity Act

Staff understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

We observed staff obtaining verbal consent from patients before providing care.

If patients lacked capacity to make their own decisions, staff made decisions about care in the best interests of patients and involved their representatives and other healthcare professionals appropriately.

Staff we spoke with told us that unless the patients representative had written proof of power of attorney, they could not consent for the scan to go ahead.

Written consent was obtained before scanning and recorded in the patient data form. An alternative form was available for patients who lacked the capacity to consent.

There was an interpreter service available to help with consent for patients whose first language was not English.

Are diagnostic imaging services caring?

Good 

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Diagnostic imaging

Patients described care as exceptional from staff. This included all the staff present.

All staff introduced themselves and communicated well to ensure patients fully understood. Patients were encouraged to ask questions and were given time to ensure they understood what was being said to them.

We observed staff interacting positively with patients and those close to them. Staff spoke to patients sensitively and appropriately depending on individual need.

Curtains were used appropriately to maintain privacy for patients in the uptake cubicles as well as a blind that was closed between the examination room and control room when a patient entered the room.

Patients were escorted to and from the examination room by clinical assistants. Those close to patients could remain during scanning if necessary.

Patients were encouraged to provide feedback about the service. Feedback from patients was monitored closely as an outcome of care and treatment provided.

Patients completed the providers patient satisfaction survey. Between April 2018 and November 2018, in the monthly satisfaction survey, 99% of patients rated their overall experience, as either a four or a five (five being the best). From the results of the satisfaction survey, patients were very positive about care received at the centre with comments including that staff were 'amazing, excellent, friendly, polite, caring, respectful and professional.'

Emotional support

Staff provided emotional support to patients to minimise their distress.

We observed staff providing reassurance and comfort to patients. Staff provided support as required. Patient comments, in the satisfaction survey included that they were put at ease, by the staff and even distracted when needle phobic.

Training in communication skills with patients was available in conjunction with the referring trust for staff to attend.

Posters were displayed for patients who may prefer a chaperone to support them.

The cubicles and examination room included relaxing scenes such as beaches as well as a skylight scene above the scanner. Dimmer switches were available in cubicles and the examination room to help create a calm setting and experience.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

We observed staff interacting positively with patients and those close to them. Staff spoke to patients and those close to them, sensitively and appropriately, dependent on individual need.

Staff respected patient choices and delivered their care with an individualised person centred approach.

Patients and those close to them told us that they received information in a manner that they understood.

Are diagnostic imaging services responsive?

Good 

Service delivery to meet the needs of local people

The service provided care and treatment for patients referred from a regional specialist trust. Patients could travel from a wide area of the north west for the procedure. There was a contract in place for this commissioned NHS service.

Patients could be either in-patients, at a hospital in the Greater Manchester area or be an outpatient.

The centre did not report or follow-up any results. The images of the scans were transferred, via an electronic system, to the referring specialist trust following their completion, on the day of scanning.

The service was located in the grounds of a NHS hospital and a service level agreement was in place for a range of ancillary services including waste management, infection control and prevention and resuscitation.

The waiting area we inspected, was free from clutter, well-lit and had adequate seating available. Signs were in place to remind relatives to prioritise seating for patients.

Diagnostic imaging

Staff we spoke to told us there was appropriate and adequate equipment available for scanning.

A hoist was available if needed, for transferring on to the examination table, although only one sling was available.

The waiting area included a water dispenser and hot drinks machine. Patients were encouraged to drink water before the procedure. A 'hot' toilet in an area restricted to staff and patients receiving treatment was available solely to patients that had received the radiopharmaceutical. Patients were provided with a hot drink and biscuit before leaving the centre.

There was a cafe and restaurant in the neighbouring NHS trust where other snacks could be purchased.

The service was routinely open between 7.30am and 7.30pm on weekdays. Extended hours and Saturday appointments had been made on an adhoc basis to manage the recent increase in demand due to the replacement of equipment at the referring specialist NHS trust and another NHS trust in the region.

Meeting people's individual needs

The service responded to patients needs on an individual basis.

The centre was located close to the emergency department of the hospital with clear signs. Car parking was available next to the centre in the neighbouring NHS trust. There were plans in place to extend parking to include dedicated accessible parking spaces next to the centre.

A ramp at the entrance, with an automatic door where patients entered, allowed accessibility for wheelchairs or for patients with reduced mobility.

All areas of the clinic were accessible for patients who required to be transported in a wheelchair.

There was a toilet available that was accessible with a dementia friendly seat and hand rails. Patients could be accompanied by someone close to them if needed including during the positron emission tomography scanning. Dementia training was included in mandatory training for all staff as well as a dementia champion on-site.

Staff gave examples of patients with learning disabilities who had attended for scans. They had been prepared before the visit and accompanied by carers for support.

A hearing loop was available for patients with a hearing impairment. An interpreter service was available for patients whose first language was not English. There was a cordless phone that could be taken in to the scan room if needed.

Any apprehension, such as a fear of enclosed spaces, was discussed prior to scanning, and included in the patient data form. Photographs of the scanner were displayed in the uptake room cubicles which showed the space available between the examination couch and the scanner. The machine was quiet compared to other forms of scanning.

The scan machine had a weight limit of 227kgs and was suitable for any bariatric patients.

There were leaflets available in the waiting area for patients to take. A safety instruction leaflet was provided to patients, or those close to them, to ensure safe management during the radioactive period following the scan. The leaflets did have images, including photos as well as text. However, there was no information in alternative formats, such as easy read and braille or languages other than English.

Access and flow

Patients accessed the service according to the appointments booked by the referring specialist NHS trust.

Between December 2017 and November 2018, there were 2,998 scans that took place. For the same time period, there were 131 patients that did not attend and 570 scans were cancelled. This was mainly for clinical reasons on the day or due to patient choice. There were 33 patients cancelled due to scanner failure.

The centre completed monthly audits to monitor any impact of radiopharmaceutical supply issues. Between January 2018 and August 2018, there were no cancellations or concerns related to the medicine supply. Between August 2018 and November 2018, 1,074 were scanned as planned. However, 109 patients needed to be cancelled due to difficulties in obtaining sufficient

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amounts of the radiopharmaceutical. We were told that there had been an increased demand for the medicines and the organisation were monitoring the supply chain and considering alternative suppliers.

The manager told us that an action plan had been implemented to reduce the cancellation and did not attend rate. Staff at the centre had started contacting patients by phone to confirm appointments to ensure that they have been given and understood any preparation needed.

Learning from complaints and concerns

There were leaflets displayed in the patient waiting area to guide patients on how to provide feedback about the service. These included directing to the ombudsman for NHS patients if not satisfied with responses from the service.

The service had not received any complaints, since the service began in 2016, and four compliments had been added to the electronic reporting system.

There was an organisational complaints policy in place and complaints handling and conflict resolution were included in staff mandatory training.

Information was shared across the organisation where any lessons from complaints from other locations could be shared and learned.

Are diagnostic imaging services well-led?

Good 

Leadership

The service had managers to run a service providing high-quality sustainable care.

There was clearly defined and visible leadership for the service. There was a unit manager, who was applying to be the CQC registered manager and the current CQC Registered Manager who was a senior radiographer.

Radiography staff understood reporting structures and told us they were well supported by their managers.

Senior managers told us that they felt supported by executives and they were approachable and contactable.

Vision and strategy

We were provided with the organisational vision and strategy that was aligned to CQC key lines of enquiry. However, this was dated 2015 to 16. Organisational values of collaboration, excellence, learning and efficiency formed the structure of the staff appraisal process.

At the time of inspection, a senior manager told us that a strategy work stream had been set up, that involved a team of staff from across the organisation with plans to launch the strategy in January 2019.

Culture

Managers at the service promoted a positive culture that supported and valued staff.

There was an open and clear culture that encouraged the reporting of incidents to learn from them and improve quality for patients accessing the service.

There was a positive attitude and culture where staff valued each other. Staff reported good team working and a sense of pride providing continuity of care using a team approach.

All staff, we spoke with, were passionate about the service they provided.

Governance

A clinical governance process was in place within the service that allowed risks to be escalated to divisional and board level in the organisation.

Organisational policies were in place as well as site specific procedures and processes including the local rules and a radiation protection supervisor. Annual radiation protection audits had taken place by the radiation protection advisor and radioactive waste advisor in September 2017 and September 2018. In 2017, it was found that all legislation was being adhered to. In September 2018, a breach of the environmental permitting regulations permit was identified and updates in documentation needed to be completed. The report provided included that lessons were learned and shared with no actions outstanding.

Waste operations require an environmental permit if the business uses, recycles, treats, stores or disposes of waste.

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All activity, at the centre was for NHS patients referred from a specialist trust. A contract was in place, with the trust. A certificate was in place from the Administration of Radioactive Substances Advisory Committee in conjunction with the trust as the certificate holder. During the extended hours to support 'swap outs' at the referring trust and another NHS trust, radiologists had agreed to provide support out of hours. However, this had not formally been agreed in the contract.

There was also a service level agreement in place with the neighbouring trust for services such as cleaning, waste management, resuscitation and fire safety. This was dated as commenced on 29 September 2016. However, the copy provided was not signed by either party.

A monthly quality and risk report was produced by the provider to share details of other locations. This included any changes in CQC registered managers, training compliance, patient satisfaction scores, complaints, audit results, incidents including lessons learned, staff radiation safety and infection prevention and control.

Clinical governance meetings were held quarterly with members invited from all divisional areas. The standardised agendas included review of previous minutes and outstanding actions across the organisation. Items discussed and reviewed included incidents, patient experience, infection prevention and control and policy updates.

There were updates for sub-committees, at the clinical governance meetings. These included the clinical advisory committee and committees for infection prevention and control, medical emergencies and medicines quality.

There was a central human resources department, for the organisation, who managed the recruitment processes. Staff files were stored centrally and not available to view during the inspection. The manager confirmed that all new employees had completed an enhanced disclosure and barring service check within the last two years and employment records for the previous five years. Employees completed health declarations for the occupational health department to review as well as other documentation including starter checklist, equality confidentiality and checks of personal radiation. Clinical

staff with professional qualifications had registration checks completed at time of recruitment and monitored registration checks annually to ensure current registrations in place.

Managing risks, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Bi-annual meetings took place for the integrated governance and risk board. Agenda items included review of previous minutes and outstanding actions. Presentations were provided by the clinical governance committee, information governance and security committee, radiation protection committee and health and safety committee. Other agenda items included training, research, regulatory updates, mobile units, positron emission tomography and computed tomography and the risk register.

There was an organisational risk register that included a section dedicated to both positron emission tomography and computed tomography scans with focus on contracts, regulatory compliance and staff retention.

Managing information

The service used electronic information to support its activities, using secure systems with security safeguards.

Information governance and data protection were included in staff mandatory training.

Electronic systems included the referring specialist trust and also the providers system. Following reporting, the stored scans were removed after a 30-day period.

There was a business continuity plan including back-up systems in case of scan electrical failure.

Engagement

Public engagement was mainly through interactions, at the centre and via the feedback form the patient satisfaction survey.

For staff, a daily 'morning huddle' took place where the days referrals and appointments were discussed as a team. Minuted team meetings took place monthly with an organisational agenda template. Items discussed

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included acceptance of previous minutes and progress of actions following the last meeting. Any concerns, updates to policies and lessons learned from other locations were shared at these meetings.

There was a requirement for a minimum of two staff to be present at the centre, to prevent lone working and as part of the agreement with the trust. Staff had parking permits and did not leave the building unaccompanied.

There were photos of staff displayed, on staff noticeboards, showing social gatherings as well as seasonal activities that took place.

A quarterly communication “one team” was shared across the organisation, from the managing director. This

included details of operations across the organisation where lessons learnt could be shared to help drive improvement. Staff were able to provide feedback in support of the service.

The student radiographer, we spoke with felt supported by the staff at the centre and was involved in all activity.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things go well and when they go wrong.

Some staff worked in other organisation locations and shared best practice. They did not carry out any research activity at the location, although the centre had only been open two years providing a service that is not routinely available in a NHS trust.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

The service should consider whether the contract with the referrer should include clear details of how out of hours radiologist support can be accessed.

The provider should consider the measures required so that sufficient medicines are available to carry out the procedure.

The service should have information available in accessible formats for people whose first language is not English.