Plymouth PET-CT Centre

Quality Report

Derriford Hospital
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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?	Requires improvement
Are services effective?	
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Plymouth PET-CT Centre is operated by Alliance Medical Limited (AML). The service is provided from a unit located within the Derriford hospital site. This service provides diagnostic imaging services via positron emission tomography–computed tomography (PET-CT) to the local community. The service also provided computed tomography (CT) scans for patients of Derriford Hospital. Following an organisational programme to transfer mobile services to static units throughout the country to improve patient experience and improve integration with local trusts, the static PET-CT Centre opened in 2017.

The registered manager was supported by a Clinical Lead Radiographer/Technologist, a nuclear technologist, radiographers and clinical assistants. Two administrators provided booking, administration and reception duties.

The unit was open on Mondays through to Saturday. On Thursdays and Saturdays, the service provided only CT scans.

We inspected this service using our comprehensive inspection methodology. The inspection was announced and took place on 17 September 2019.

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

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

Services we rate

Our rating of this hospital/service stayed the same. We rated it as **Good** overall.

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills and understood how to protect patients from abuse. Staff assessed risks to patients, acted on them and provided detailed scan reports. The staff reported incidents, and learning was shared within the service and across the wider organisation.
- Staff were trained and competent and provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. The service was available five days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and enabled patients to give feedback. Patients could access the service when they needed it and did not have to wait too long for their diagnostic test.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work.Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services.

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

- Staff did not fully promote the control of infection as they did not consistently follow hand hygiene procedures. Cleaning materials were not securely stored and were accessible from areas patients used.

Summary of findings

- Environmental risk assessments did not ensure the safety of the patients and staff. Routine checks had not been consistently completed to ensure the emergency equipment was ready for use.
- A robust checking procedure to ensure the right patient was scanned at the right time was not consistently followed prior to completing patient scans.
- While staff reported incidents and learning was shared, practice was not consistently reviewed and developed to reduce the risk of the same incident reoccurring. When things went wrong a written apology was not provided in line with the duty of candour legislation.

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

Nigel Acheson

Deputy Chief Inspector of Hospitals (area of responsibility)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	

Summary of findings

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Summary of this inspection

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Good

Plymouth PET-CT Centre

Services we looked at:
Diagnostic imaging

Summary of this inspection

Background to Plymouth PET-CT Centre

Plymouth PET-CT Centre is operated by Alliance Medical Limited (AML) and provides PET-CT and CT scans for both NHS funded and private patients. A PET-CT scan is a combination of two types of scanning technique in which a small amount of radioactive tracer (a type of fluid) is injected into a vein. This provides information about the anatomy (CT) and function (PET) of your internal organs. CT (Computed Tomography) is a scanning technique which uses X-rays and a computer to create a series of cross-sectional images of structures inside the body, including the internal organs, blood vessels and bone.

The service registered with the CQC in 2017 and this is the first inspection of the service. Previously the service was carried out as a mobile service.

The service has a registered manager who has been in post since January 2019.

The service provides PET-CT and CT scanning services for patients aged 18 years and above.

Our inspection team

The inspection of the service was carried out by a lead CQC inspector supported by a second CQC inspector and a specialist advisor.

The inspection team was overseen by Amanda Williams, interim Head of Hospital Inspection.

Information about Plymouth PET-CT Centre

The service is registered to provide the regulated activities: diagnostic and screening procedures.

The service operated on a Monday, Tuesday, Wednesday and Friday providing PET-CT scans and on a Thursday and Saturday providing CT scans.

We spoke with six staff including the registered manager, nuclear technologists radiographers a clinical assistant and administration staff. We spoke with six patients and three relatives. During our inspection, we reviewed five 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 first inspection of this service since its registration in 2017.

Activity (August 2018 to August 2019)

In the reporting period August 2018 to 16 sept 2019 there were approximately 2300 clinic appointments recorded at the service; 2179 of these were NHS-funded appointments.

Staff employed

At the time of our inspection seven members of staff were employed at the service. The service was led by the registered manager supported by the clinical lead – a senior nuclear technologist one nuclear technologist, two radiographers, one clinical assistant and one administrator who also had a role as clinical assistant.

Track record on safety

- No never events had been reported in the last year
- Eight clinical incidents had been reported within the service over the last year
- Six complaints had been made over the last year

Services accredited by a national body:

- The Quality Standard for Imaging (QSI – formerly known as ISAS) renewal date July 2021.
- Information governance info security standard (ISO27001) renewal date June 2021
- Investors in People, renewal date March 2020

Summary of this inspection

Services provided at the service under service level agreement:

- Clinical and non-clinical waste – service level agreement with the acute trust.
- Domestic cleaners – service level agreement with the acute trust.
- Maintenance and servicing of medical equipment via external organisations through contractual and servicing plans.

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?

Requires improvement 

This service had not previously been rated. We rated it as **Requires improvement** because:

- Staff did not consistently carry out appropriate checks prior to the scan to ensure the right patient was having the right scan at the right time.
- Staff did not follow the infection control policies and procedures in that they did not consistently clean their hands between each patient contact. Cleaning materials which were hazardous to health were not stored securely.
- Emergency equipment was not checked consistently, which was not in line with the organisations policies and procedures.
- Risk assessments did not provide a clear overarching assessment of the environment to maintain the safety of patients and staff.
- Patients did not receive a written apology and explanation when care and treatment had not been delivered as expected or planned.

However, we also found the following areas of good practice:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff were trained to use the equipment required to carry out the service offered to patients.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Summary of this inspection

Are services effective?

We do not rate the effective domain in diagnostic services.

- The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.
- Staff checked if patients required support with eating and drinking to stay healthy and help with their recovery.
- Staff assessed and monitored patients regularly to see if they were comfortable.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Staff supported each other to provide good care and communicated effectively with other agencies.
- The service was available six days a week to support timely patient care.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Are services caring?

Good

This service had not previously been rated. We rated it as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Are services responsive?

Good

This service had not previously been rated. We rated it as Good because:

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

Summary of this inspection

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Are services well-led?

Good

This service had not previously been rated. We **rated it as Good because:**

- The registered manager had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Summary of this inspection

- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

However:

- While leaders operated governance processes, throughout the service and with partner organisations not all areas of concern had been identified. For example staff not complying fully with infection control procedures or carrying out robust checks to ensure the right patient had the right scan at the right time.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

Good

Diagnostic imaging

Safe	Requires improvement
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement.

Mandatory training

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

- Staff completed mandatory training annually. The mandatory training was completed on line and all staff completed the following areas: corporate and local induction, complaints handling, conflict resolution, data protection, equality and diversity, fire safety at work, health and safety awareness, infection control, information governance, managing violence in the work place, safeguarding children and adults at level two and data integrity.
- The unit provided role specific mandatory training. This included the use of radiation and associated risks and refresher scenario sessions were provided for the clinical staff every three months to ensure their skills remained up to date. The registered manager had completed level three safeguarding training. Moving and handling training was completed by all staff with the clinicians trained in moving and handling people and non-clinical staff in moving and handling objects only.
- All staff were up to date with their mandatory training. The registered manager had access to all staff training records on line. Staff training compliance and goals was discussed as part of a twice yearly assessment to ensure staff were up to date. Out of the seven members of staff, six were 100% compliant. One new member of staff had face to face training booked to complete life support training – this would then complete their programme of mandatory training. The registered manager had evidence this member of staff had completed recent life support training with their previous organisation.
- Staff made positive comments about the quality of the content of the training and stated it equipped them for their roles.

Safeguarding

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

- Policies and procedures existed to provide guidance and information to staff to support them in recognising and reporting any suspected safeguarding issues appropriately. Information was available to the staff regarding external contacts within the local authorities to enable appropriate and prompt reporting of any safeguarding concerns. Patients had access to appropriate information to enable them to report any safeguarding concerns from posters displayed in the waiting area.
- All staff had completed training to safeguard adults and children from abuse at level two which complied with national guidelines and the organisations policy and procedures. This would enable them to recognise potential abuse. The registered manager had completed safeguarding adults and children training

at level three and would be able to support staff with any concerns identified. Staff were informed of the organisation's safeguarding lead within the policy and procedure.

Cleanliness, infection control and hygiene

Staff did not consistently follow infection control procedures fully to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

- The service had infection prevention and control (IPC) policies and procedures which provided staff with guidance on appropriate IPC practice. For example, hand washing and waste management. The registered manager was the infection control lead for the service. All staff were compliant with the on-line annual IPC training module.
- We observed staff did not consistently wash their hands before, during and after patient contact. This meant the service did not always meet National Institute for Health and Care Excellence (NICE) QS61 statement 3: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. Hand washing facilities and sanitiser gels were available in the reception and in all rooms. Information charts about hand hygiene were displayed within the clinical areas. We observed staff to be bare below the elbow.
- The service had access to cleaning materials. The service maintained information relating to the control of substances hazardous to health (COSHH) which advised staff of risks associated with the cleaning materials. The cleaning materials were stored unsecured in a cupboard close to where patients were unattended. The materials included chlorine tablets which, if accidentally ingested were hazardous to health.
- There had been no incidences of a healthcare acquired infection over the past year. Staff were aware of the procedures when providing a diagnostic service to a patient with an infectious illness. Patients booked for a scan who had a known infection were scanned at the end of the day so that the clinical areas could be cleaned appropriately before use by another patient.
- The service carried out monthly IPC audits which included checks of the environment, waste management, spillage/contamination with blood/ body fluids, use of protective personal equipment such as gloves and aprons and hand washing, including hand washing facilities. The monthly audit provided an action plan for any identified issues and named staff responsible for addressing the issues. The outcomes from the monthly audits were submitted to the organisation and an annual IPC audit was completed by the Quality and Risk team.
- Staff cleaned equipment between each patient and at the end of the day. Domestic cleaners attended the department daily to clean the patient and staff areas. The exception to this was the scanning room which staff had responsibility for cleaning. We observed appropriate cleaning procedures for all PET/CT equipment, following its use. All areas of the premises were observed to be clean, tidy and visually hygienic. A record was maintained of the areas cleaned, by whom and when. The areas included the scan room, uptake areas (cubicles where patients waited for their scan) and corridors.
- We saw sharps disposal bins (secure boxes for disposing of used needles) located in clinical areas to ensure the safe disposal of sharp items. Labels were correctly completed to inform staff when the sharps disposal bin had been opened and the bins were not overfilled.
- Legionella Testing (Health and Safety) was carried out as per local policy. The staff maintained records to identify each hot water outlet tap was run for at least two minutes each week to reduce the risk of legionella bacteria. An annual legionella test was carried out by an external organisation. The last being carried out in June 2019 for which organisation was awaiting the report and certificate at the time of our inspection.
- An annual deep clean was carried out by an external service through a corporate contract. We saw evidence which identified this had been completed in March 2019.
- Staff were trained in intravenous cannulation and understood the need to monitor cannula sites. A monthly audit was carried out regarding the use of peripheral vascular devices for individual staff

members. There had been one occasion in the last year when the correct process had not been followed in that an appropriate dressing had not been placed over the insertion site. Learning following such audits was shared with staff at the daily safety huddle which all staff attended.

- Spill kits were easily accessible to ensure the safe management of accidental spillage. The kits included the personal protective equipment and disposal equipment needed.

Environment and equipment

An environmental risk assessment had not been carried out for the premises to give a clear oversight of the building and any associated risks. The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

- The service operated from a self-contained unit on the site of the acute hospital. The building was secured when not in use and monitored by CCTV on the outside and inside of the building. Security of the building was maintained by staff. The trust site security checked the building at night, and keys were securely managed. The first member of the team to arrive each morning did an initial check of the building.
- Risk assessments had been completed regarding risks associated with the use of equipment but there was no overall risk assessment for the building and environment to ensure the safety of patients and staff. For example, assessing risks from disability access and lone working.
- Equipment was not always stored safely when not in use. For example, at the time of our inspection, there was a patient stretcher trolley and a hoist not in use. The organisation was due to remove these from the site. The stretcher trolley was located within the main corridor partially blocking the fire exit. The registered manager addressed this risk immediately after the inspection by storing the trolley elsewhere while the collection was awaited. There was limited storage space within the building.
- The provider had a maintenance and servicing contract for the scanning machine with an external organisation in line with the manufacturers guidance and recommendations. The scanning machine was serviced each quarter. Support was also provided by the medical engineering department to service and maintain other medical equipment used by the service. Each item displayed a sticker to show when the last service or check had been carried out. we observed two stickers identified that a service was overdue. However, the registered manager provided records which showed the equipment had been checked but the sticker not renewed. The equipment was labelled correctly during our inspection to ensure staff were confident the servicing and checks had been carried out.
- The medical physics department from the acute trust carried out annual safety checks within a service level agreement. These included calibration checks, the management of waste radiation to ensure the regulations of the Environment Agency permit were complied with. A clinical audit of injection residues had been completed. The medical physics team had also been involved and signed off the risk assessments for the use and management of the CT and PET-CT scanning.
- The essential maintenance of the building such as repairs to locks and doors and fire checks were carried out by an external organisation within a service contract.
- The clinical lead had the responsibility for training new staff in the use of all medical equipment. Written records were maintained which showed staff training and competencies had been assessed.
- Emergency equipment for resuscitation and allergic reaction were stored securely. The equipment included emergency medicines, oxygen, suction and cardiac monitor. The suction machine did not have an accurate record of when it was last serviced and so it was not clear if it had been confirmed as suitable for use. Checklists were available for staff to complete following weekly and daily checks of the emergency trolley and resealed to ensure it could be identified if tampered with. Some gaps were seen in the daily checking. This meant that staff could not be assured of all equipment being available when needed.

Assessing and responding to patient risk

Good

Diagnostic imaging

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

- Staff recognised and responded to patients who presented as acutely unwell during and on the findings from the scan. Patients who required urgent onward referral were managed in compliance with policy and local procedure. The service was supported by the trust radiologists who provided advice and were available by telephone when the service was in operation. The trust emergency response team were able to be summoned in a medical emergency, for example if a patient had a cardiac arrest. Staff trained in intermediate life support were always on duty and would respond to any patient who became acutely unwell. During the previous year one patient had become acutely unwell while in the department and they were transferred promptly to the acute hospital. Staff were knowledgeable about carrying out additional physical observations and following the national early warning score (NEWS) system to monitor the deteriorating patient. The NEWS is a tool which improves the detection and response to clinical deterioration in adult patients by the monitoring and appropriate reporting of the patients physical observations.
- The service was supported by the Plymouth Hospital University NHS foundation trust medical physics team who provided a radiation protection advisor, medical physics expert and radioactive waste advisor. Good working relationships had been established and the medical physics and radiation protection advisors supported staff on site regarding sharing best practice and advice on safe delivery.
- Staff did not consistently follow a six-point check to ensure the right patient was having the right scan. We observed that patient details were checked at reception and then called through to clinical areas where they were shown to a cubicle to prepare for the scan. We observed two patients were then taken into the scanning room and helped onto the scanning machine. The clinician did not carry out any further checks at this point. Prior to the scan commencing the clinician asked the patient if they were happy with a given date of birth. This process is not as robust as asking the patient to give their name and date of birth. This increased the risk that the wrong patient could have the wrong scan,
- A checklist was used to reduce the risks from the use of CT contrast. This included checking for allergies, blood tests to check kidney function such as creatinine levels and the possibility of pregnancy. There were signs throughout the building to alert patients and staff to the risks of the treatment when pregnant. When appropriate, staff questioned the patient regarding potential pregnancy. The patients renal function was checked on blood results provided by the referring clinician prior to the scan taking place.
- Staff confirmed they referred any urgent or unexpected findings on the report to the appropriate clinician at the acute trust. Images were transferred onto CDs which were stored securely by the service. However, staff stated they did not re run the CD to check the images had been successfully transferred.
- Local rules (IRR) were on display in the control room from which the scanning machines were operated. The rules had been updated following changes in IR(ME)R guidance and legislation in 2017 with a future review date identified to be September 2020. The local rules were recorded on an organisational wide template but had been localised by the Radiation Protection Advisor (RPA) in April 2019.
- Employers IR(ME)R procedures for medical exposures in imaging were available and comprehensive.
- Where inpatients from the trust were referred to the service, effective handover of their clinical information was obtained and documented to support continuity of care. Liaison with the referring ward was carried out on the morning of the scan to ensure the pre-scan requirements had been followed, for example, fasting if required.
- A safety huddle took place each morning which all staff attended. This included a review of the patients attending the service in the day, staffing levels and wellbeing, appointment times and equipment.
- Staff gathered further information from the referrer and acted to reduce the risks to staff and other patients. For example, information was gathered on

the risks from violence and/or aggression from patients with a mental health illness or dementia. Patients attending from the local prison were booked at appropriate times when there were fewer patients in the department. This also promoted their privacy and dignity.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

- Plymouth PET-CT centre was led by the registered manager and staffed in line with the staffing requirements as stated in the organisations support of a safe scanning pathway policy. The minimum level of staffing to provide a safe service is two technologists/ radiographers and one clinical assistant with at least two staff on duty who had been trained to manage medical emergencies and recognition of the deteriorating patient.
- At the time of our inspection the service had 1.5 whole time equivalent (WTE) vacancies. Recruitment was ongoing to fill these roles.
- The service did not use agency staff. Additional shifts were provided by a bank radiography staff member who worked regularly within the service. The registered manager arranged cover for sickness and annual leave by booking bank staff or authorising permanent staff overtime shifts.

Records

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

- The service used a secure electronic system, which was password protected, to maintain patient records including the scan report and test results. Paper records such as the booking forms and associated patient confidential information were scanned, uploaded to the electronic system and then securely shredded.
- All patient and clinical information was recorded on the organisation's electronic patient record system. The exception to this was the storage of CT images which were stored onto a compact disc which was stored securely. Reports were sent out electronically by email to the referring clinician. Referring clinicians from the acute trust could access the electronic storage system for CT images. The PET-CT scanning machine facilitated a system to export images to the system used by the acute trust to enable clinicians to review these images. For referring clinicians who could not access the trust systems, the images were sent via the internet, using secure password protected systems and a read receipt obtained to ensure the image had been received.
- Repeat scans were arranged following a reminder email from the electronic system.
- Records and information were well managed. Each staff member used a secure log-in to access the patient's information. All booking referrals were received via electronic transfer and the administrative staff contacted the patient directly. Details were gathered, and an appointment date agreed. Any important information was recorded at that time, this included issues which may impact on the scan. Staff sent out an appointment letter by post or email, dependant on patient choice. Both formats included details of what to expect during the scan and details of the injected solutions.

Medicines

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

- Staff were provided with a policy and procedure regarding the management of medicines in use in the service. For example, the use of Intravenous contrast media. The organisation had appointed a pharmacy advisor who supported staff with national requirements and policy and procedure updates.
- No controlled drugs were used or stored.

- The registered manager was the service lead for the safe and secure handling of medicines.
- Specialist pharmacist support from the acute trust had been arranged within a service level agreement.
- Patient Group Directions (PGD) were in use for the administration and use of contrast in CT scans. These had been written and signed off by a pharmacist. All staff were knowledgeable of the content and signed to say they had read the directions. PGDs provide a legal framework that allow the registered health professional to supply and/or administer specified medicines to a pre-defined group of patients without them having to see a prescriber (such as a doctor or nurse prescriber).

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. However, the risk of repeat incidents occurring had not been fully mitigated against.

- No never events or serious incidents had been reported in the past year.
- There had been one IRMER/IRR reportable incident which occurred in the service in the last year. This involved a duplicate and unnecessary CT scan for one patient which meant they had received an increased level of radiation. The service had reported this as an incident and investigated appropriately. The trust medical physics CT specialist had looked at data to identify any significant risk to patient and produced a report. Learning had been shared with staff regarding this error with the intention of reducing the risk from the incident reoccurring. However, we observed during our inspection that nationally recognised systems for checking the identity of the patient were not consistently followed prior to patients receiving their scan. This meant that there was a risk of the wrong patient having the wrong scan at the wrong time.
- The reporting, investigation and management of incidents included and supported learning and development at unit level and across the wider organisation. Staff used an electronic system to report incidents and near misses which were reviewed by the organisation.
- Administration staff knew how to raise an incident but had never had too. Administration staff held a regional wide teleconference each morning to discuss capacity and management and this included sharing information about any incidents.
- Learning from incidents is shared via a monthly risk bulletin which all staff had access to. The daily safety huddle highlighted and reflected upon any incidents which had occurred in the service and wider organisation. Further discussion took place at team meetings. The registered manager attended the south west managers meeting every other month during which incidents were reviewed and discussed to promote patient safety and learning.
- There had been eight incidents in the past year, four of which had been regarding a delay in the manufacture and delivery of the isotope which meant the patient treatment had been delayed.

When things went wrong, staff apologised and gave patients honest information and suitable support. However, this was not followed up with a written apology.

- The registered manager was aware of the duty of candour requirements with staff being open and honest in the event of any level of harm. Information and guidance for staff was provided within the incident reporting policy and procedure. We observed that a verbal apology had been offered to one patient where their treatment did not follow the right procedures. There was no evidence of the duty of candour policy being appropriately followed by the information being provided in writing.

Are diagnostic imaging services effective?

We do not rate the effective domain in diagnostic imaging services.

Evidence-based care and treatment

Good

Diagnostic imaging

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

- Staff understood and followed best practice guidance including the Administration of Radioactive Substances Advisory Committee and Ionising Radiation (Medical Exposure) regulations.
- Policies and procedures were made available to staff at provider and site-specific level for the service. For example, in relation to Ionising Radiation Regulations (2017) which regulate the protection against exposure to ionising radiation due to staff roles. The scanning protocols and procedures were reviewed and approved by a consultant radiologist.
- Staff signed to say they had read and understood the policies and procedures. When policies and procedures were updated, staff were advised by the organisation or registered manager of the change and often updated policies were highlighted and discussed at team meetings.
- Image and reporting quality were audited within the service and compared to national outcomes across the organisation. An audit of 10% random scan reports and images was carried out each month. Comments were made when necessary and reported to the local service for review.

Nutrition and hydration

Staff checked if patients required support with eating and drinking to stay healthy and help with their recovery.

- Patients were provided with specific instructions relating to eating and drinking prior to their scan within the appointment/booking information. This included fasting and only drinking water for a period of time.
- Diabetes management was considered at the initial safety review. If patients had type one diabetes they were booked for their scan late morning. This enabled the patient to have their insulin, breakfast and then be nil by mouth for four hours. If patients were type two diabetes, they had earlier morning appointments to enable them to miss medication and breakfast and so be nil by mouth for their appointments. The blood sugar levels of patients were checked on arrival at the centre.
- Biscuits, hot and cold drinks were available and patients were recommended to sit in the waiting room while they had a drink and biscuit before leaving their appointment.

Pain relief

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

- The scanning procedures were painless, but staff monitored and checked with patients throughout the scan to ensure they were comfortable. Staff assisted patients to access the scanning machine and helped position them appropriately.
- No pain relieving medicines were available within the service.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.
- The service carried out regular audits of the service provided. These included an annual infection prevention and control audit, policy audits and monthly quality reviews imaging and scan reports. The audits identified any shortfalls and included an associated action plan. For example, the quality review of images provided comments on five images out of 1986 scans completed.
- All PET-CT reporters were included in the national programme of audit scheme. This is a randomised 10% surveillance audit undertaken by auditors independent to the reporting clinicians. At Plymouth PET-CT this was a centrally coordinated audit process

carried out by the organisation. The results were held centrally, with feedback provided throughout the year to reporters to allow for reflection and improvement of practice.

Competent staff

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

- New staff were provided with induction training which included: a one day corporate induction held at the company head office and a local induction. The local induction followed a checklist specific to the site including; local rules, equipment, patient pathways, emergency drugs, administration systems, staffing shifts, policies, complaints and incident reporting procedures. A mentor was allocated to new staff and provided support with their induction programme and also through their six-monthly probation period. One member of staff confirmed their induction had been thorough and covered relevant areas needed to start work. Ongoing work support had been provided.
- All staff working at the service over the past year had received an annual appraisal. The annual appraisal was linked to a pay review and completed jointly by the staff member and the registered manager. Topics discussed included mandatory training, core values and behaviours, career conversation, and a learning development review. Additional comments were included from both the registered manager and the employee. The appraisals were reviewed by the regional manager prior to being held by the organisation's human resources department. A further mid-year review of individual objectives also took place.
- Role specific training was available to staff in addition to the mandatory training. For example, a dementia awareness course, patient communication and anaphylactic shock training specifically around CT. Administrative staff told us they could access training at hospitals in Manchester and Southampton. Courses they had attended included train the trainer and customer services.
- Role specific continuous development and maintenance of existing skills and competencies was an ongoing process. For example, peripheral vascular device insertion. Audits took place monthly to ensure staff maintained their competency and provided good outcomes for patients during their appointment at the centre. One radiographer had attended a radiation protection supervisor (RPS) course last week. One member of staff was due to attend human factors training the week after the inspection.
- Staff were encouraged to attend training events and courses. An external on line training provider was accessible to staff and provided notifications of courses and conferences. Staff commented that the attendance at training was limited to the staffing numbers and covering the service. Once approved staff, were paid for their attendance at training/ conferences and if necessary accommodation and travel costs were met by the organisation.
- The service held records to show that the professional registration for the clinicians was checked annually with the professional body. For example, radiographers were registered with the Health and Care Professions Council.

Multidisciplinary working

Staff supported each other to provide good care and communicated effectively with other agencies.

- A monthly meeting was held with the medical physics team at the acute trust. Minutes of the meetings were maintained which identified various topics were discussed including emergency contingency plans, any reported radiation incidents and review of the monthly radiation scenario training provided to staff.
- Staff contacted wards, surgeries and other health care professionals to discuss any specific health care needs in preparation for the scan. They telephoned all patients or their carers to discuss the preparation needed and confirmed all conversations with an email or letter.
- Staff liaised with clinical nurse specialists, chest clinics, oncology and nuclear medicine before booking scans to ensure they had all the information needed to support the patient.
- Staff worked closely with consultants from the acute trust. Liaison and communication took place by

telephone, email and in face to face meetings. Staff stated that the consultants attended the unit to observe some scans for example, an urgent scan for an acutely unwell patient.

Seven-day services

The service was available six days a week to support timely patient care.

- The service provided PET-CT scans on Monday, Tuesday, Wednesday and Friday from 08.30 to 20.30 hours. CT scans were provided on Thursday and Saturday from 07.30 to 19.30

Health promotion

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

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

Consent and Mental Capacity Act

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

- Patients were provided with written and verbal information prior to their appointment to enable them to understand the planned diagnostic test.
- Patients received a consent to treatment form prior to the appointment, this gave them time to read it carefully and fully before consenting. We saw that one patient had forgotten to bring the form, so another one was printed for completion prior to treatment. Each patient was reviewed at the time of the scan and consent discussed again.
- Staff were knowledgeable about how to support patients who lacked the capacity to make decisions about their care or those experiencing mental ill health. The decision to carry out the planned scan would be discussed with the patient, their representative and other health care professionals as necessary.
- The morning huddle was used as an opportunity to make staff aware of any patients who had special requirements. On the day of inspection staff identified a patient who was vulnerable and another patient living with dementia. This enabled staff to be prepared and to ensure the patient experience was tailored and safe.

Are diagnostic imaging services caring?

Good

We rated caring as **good.**

Compassionate care

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

- Each patient was provided with a cubicle known as the uptake room, to change into any gown or clothing needed. Each cubicle had a basket for the patients' belongings to be stored safely. The cubicles had close circuit television (CCTV) which was covered by a curtain when patients were changing. The CCTV was used to enable patient's privacy but staff could ensure their safety.
- Notices were displayed in the patient areas regarding chaperoning. Should a patient wish a member of their family or friend to remain with them in the cubicles there was information to advise them of the ionising radiation procedures to maintain their safety. Chaperoning was provided by clinicians and administrative staff confirmed while they would be prepared to undertake this role, they had never been asked and had not been provided with training for this.
- Patients were supported in the uptake rooms by staff who were kind and helpful.

Good

Diagnostic imaging

- A privacy blind was used between the scanning room and the control room to promote the patient's privacy and dignity.
- Patients told us that "Staff have been extremely good and extremely helpful. When there was a problem with the scanner, they fitted me in elsewhere." Another patient told us " They rang to say they were running late, that was unexpected but welcome".
- Patient surveys were available in the waiting room ready for completion. One patient told us they had completed the survey and had found the service to be extremely good and staff had been kind. This had been reassuring to them. The organisation monitored the outcomes from patient surveys and action was taken when necessary to address any issues. For example, one patient had requested up to date magazines in the waiting room and this had been addressed.
- On arrival patients spoke with the receptionist. We saw that administration staff would stand and speak to patients to ensure dignity and confidentiality were maintained. When needed staff left the office to speak to patients quietly.
- Patients were respectfully called by their name from the waiting room. Staff received training on communicating effectively with patients and followed the national 'hello, my name is' process to introduce themselves and reassure the patient. We saw staff consistently identified themselves by name and role.

Emotional support

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

- The administrators telephoned all patients to make an appointment. During this telephone call the process was fully explained and patients had the opportunity to ask questions and were provided with reassurance regarding the procedure. Patients told us that they had all appreciated the telephone conversation prior to the appointment. The explanation of the process had helped to reduce their anxiety. One patient told us "I was very stressed, but I am ok now".
- We observed staff checked regularly that the patient was okay during the procedure.
- Music was played in the uptake room to help the patients relax.

Understanding and involvement of patients and those close to them

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

- Following the initial telephone call to the patient, a written letter, consent form and information relating to the procedure were sent to the patient. On arrival at the centre patients had the opportunity to ask any further questions.
- Staff advised the patients of the process and provided explanations and reassurances throughout their time in the centre.
- Administrative staff told us that patients often telephoned after the scan, anxious about the results. We overheard two of these conversations. Staff were very kind and supportive and gave helpful information and advice. They provided further contact telephone numbers if patients felt they needed to call again.
- We spoke with three relatives who told us they found the service to be efficient and helpful. All knew the process being followed and who to contact for information.

Are diagnostic imaging services responsive?

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

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

- The service was commissioned by an acute NHS trust to patients referred through the NHS.
- The service provided PET-CT scans on four days and CT scans on two days each week. Additional clinics

were opened, and appropriate staff recruited to meet increased demand. For example, CT scans had been available on one day a week but this was increased to two days. Choline PET scans were allocated for Tuesday afternoons with an option to include on Fridays if there was an increased demand.

- Parking was available nearby to the centre on the hospital site with charges set by the acute trust. Public transport was available and accessed the hospital site.
- The environment was appropriate, and patient centred. The waiting room was small but adequate seating was available for the number of patients and relatives attending the clinic. There were two toilets available, with one exclusively for patients receiving radiation treatment, to prevent the risk of cross contamination.
- Information about the unit and the procedure was provided with the appointment details. Staff were further available by telephone to discuss any concerns. When booking appointments, staff considered the time and location of each patient. The first appointments of the day were always used for people in the local area. This meant if the appointment needed to be cancelled, the staff would ring the patient and delay them leaving, instead of patients already travelling a longer distance. Patients arriving by ambulance were accommodated in line with availability of transport. The location and distance to the organisation was produced electronically at booking stage to ensure staff had booked a local address.
- For those patients coming from the inpatient wards, timing was considered to support their other medical needs. Patients medicines and treatments were considered and appointments fitted around the needs of the patient.
- The service carried out medical trials, working with an external organisation, which offered patients the opportunity to be involved in new treatments.

Meeting people's individual needs

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

- Translation and interpretation services were available on request via a telephone service line for patients whose first language was not English. Staff said relatives were welcomed to attend the appointment and assist with basic translation but not with the translation of medical information. A registered translator would be used for this purpose. Arrangements could be made to support patients with the provision of sign language. A hearing loop was available at reception but not elsewhere in the centre.
- Information was not available in any other format than English. Staff told us they had never been asked for an alternative format and would use a translation service to verbally explain if needed.
- For patients who were visually impaired, staff ensured that an appropriate person would be able to read the safety questionnaire and consent questions and complete the form on the patients behalf. Guide dogs were able to enter the building but no further than the waiting area.
- Disabled access complied with the disability discrimination act requirements. The environment was all on one level, with suitable access near the door for patients with mobility issues. A dedicated ambulance bay was located next to the unit to enable inpatients at the acute hospital or from a care home easy access to the unit. There was a drop off point outside the unit to enable those patients to be seated quickly while their driver parked the car. Staff had access to a parking code to enable easier access when patients were leaving the unit. Patients attending on a trolley were taken straight to the scanner as there was no available waiting space for them. We observed that patients with extra mobility needs were supported to access the unit safely. Staff had access to mobility aids to assist patients such as a patient slide and transfer board and completed manually handling training each year.

Good

Diagnostic imaging

- For patients with a learning disability who required support from their carer, the carer was able to stay with the patient for the PET scan but not for the CT scan. The carer would be able to talk to the patient from the control room.
- Patients who suffer with claustrophobia could find the scan daunting. In this instance, and if known about before the appointment, the patient was encouraged to visit their GP and obtain a prescription for a sedative by their GP. The staff liaised with the patient regarding the optimum time to take the sedative to correspond with the scan time.
- For patients with mental health needs staff would support them as much as possible, however staff had not received any training to support patients with mental health.
- The staff had never experienced any challenging or aggressive behaviour and told us that they could access security staff for assistance if needed. Staff had been provided with training on managing violence and aggression and communication skills.
- Appointments were booked for both Plymouth and also the Torbay, Cornwall and Somerset locations. Appointments could be changed by the patient contacting the administrative staff. Delays were managed to prevent excess waiting by patients. We saw one patient had received a call that day to say that they would be delayed by 30 minutes.
- Patients and staff told us that the length of appointment was sufficient to discuss the process and for patient details to be checked.
- The waiting room had reading materials and information displayed relevant to the service, this included attendance statistics and how to make a complaint.

Access and flow

- People could access the service when they needed it and received the right care promptly. The contract was commissioned by NHS England and required patients to be scanned and the images together with the associated report returned to the referring clinician within 7 days of receipt of the referral. The exception to this was if there was a clinical indication for the scan to be booked for a specific date such as treatment or surgery.
- Referral forms were received via NHS.net emails and were checked by administrative staff and entered onto the electronic system ready for the booking process. There was a maximum of 15 scan times available each day. If there was only one staff member available to scan that number reduced to eight scans a day. Each referral had the time the referral was made and the timescale for the scan. This could be to meet a target date or in preparation for a planned consultation. If the scan was needed urgently or required a specific date to fit around pre-planned treatment, for example chemotherapy, radiotherapy or surgery, these appointments took priority in the booking process.
- Appointments were available in other areas, to ensure patients were seen promptly. Each morning administrative staff discussed capacity across the region. If it was not possible for a patient to be seen in Plymouth they were allocated an appointment, with the patients' agreement, in another centre, for example Taunton. If there was a surge of demand, an extra day of appointments would be organised.
- The patient was contacted by telephone to complete the booking process. Where reasonable, the next available appointment space was allocated. If needed, a longer working day was planned to meet demand.
- When patients did not attend a pre-booked scan, a reminder letter was sent with a further appointment. Staff would attempt to telephone the patient to establish the reason for the absence and ensure the scan was rebooked. Should contact not be successful or the second appointment not kept, then the administrative staff would contact the referrer and discuss the next course of action.
- Over the past year, 100 appointments had been cancelled for a non-clinical reason. This was mainly due to failure of patient transport and the radioisotope not being delivered on time or being delayed by the manufacturing process. The radioisotope was a form of natural elements used to

pass through the body and be detected by the scanner. A leaflet was sent to patients explaining the process of the isotope being made in Guildford and being transported to Plymouth.

- The maintenance and servicing of the scanner resulted in half a day scanning time being lost each quarter and was planned into the appointment scheduling. When appointments were cancelled the patient was rebooked as soon as possible.
- Results were reported within two to three working days and the reports sent by the allocated radiographer to the referring clinician. Should there be two clinicians the results were sent to the primary referrer and the second consultant could request a copy. If the scan and report were undertaken privately the reporter is selected from a choice available.

Learning from complaints and concerns

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

- The organisations concerns and complaints leaflet was available in reception. Patient told us that should they need to raise any concerns or complaint they would start by speaking to the staff.
- The service had received four complaints in the last year all of which were upheld following a thorough investigation and communication with the patient. The service verbally apologised to the patient when things went wrong in compliance with the Duty of Candour regulations.

Are diagnostic imaging services well-led?

Good

We rated well led as good.

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

- The registered manager, known within the service as the unit manager, was based at the centre and visible and approachable to staff. Support was provided to the registered manager by a regional manager. The regional manager and registered manager met every two months. This provided the regional manager with the opportunity to speak to all staff on site during their visit. Staff we spoke with were aware of the leadership roles and understood the reporting structure.
- The registered manager had been in post since January 2019 and on appointment provided with a corporate induction training programme. The content of this had been appropriate for management staff. For example, training included staff management, budgets and financial constraints. The registered manager had achieved formal nationally recognised management qualifications prior to being employed by the organisation.
- The registered manager understood the needs of the service well, through attending regional and national meetings and liaising with the commissioners of the service.
- Staff made positive comments about the support they received from the manager.

Vision and strategy

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

- The organisation had developed a corporate vision, values and strategy which had been shared with the staff. A strategy wheel had recently been produced by the organisation together with information booklets

which had been provided to all staff. The registered manager described the aim of which was to engage all staff and improve communications across the organisation.

- Staff told us while they had an awareness of the values, they had not been involved in the development of them and were unsure of the strategy to meet the values. The values included Efficiency, Leading, Excellence, Collaboration and Openness.
- Leaders of the service consulted with the acute trust to ensure the service met demand.

Culture

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

- The service encouraged and welcomed feedback from patients and their representatives. Quality surveys were provided for patients to give their view of the service provided. Information was available providing the complaints procedure.
- Staff felt able to report incidents to share learning and improve the quality of the care provided to patients.
- There was a positive culture amongst the staff team and staff valued each other. The registered manager spoke with pride regarding the small staff team working at the service and how they all worked together to deliver an efficient and effective service to patients. It was apparent when talking with staff that the patient was at the centre of the service provided.

Governance

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

- Policies and procedures were available to staff on the company website and were reviewed regularly and updated in line with national guidance and legislation.
- Staff were recruited in line with national guidance and the robust recruitment process ensured staff were competent, capable and confident in their area of practice. The registered manager was supported in the recruitment processes by the organisation's human resources department.
- The registered manager attended regular service review meetings with the commissioners of the service. The meetings reviewed key performance indicators and the outcomes of such meetings discussed at staff meetings as appropriate. This meant staff were kept involved with the outcomes.
- There were service level agreements in place with the acute trust to provide services such as cleaning, waste management, security and fire safety. These were reviewed regularly.
- Monthly meetings took place with the clinical lead, registered manager and the radiation protection advisor (RPA) to ensure the service was meeting the radiation safety requirements . The dose rates recorded by staff were shared each month with the RPAs to ensure any potential safety concerns to staff and patients were identified and addressed.
- The organisation held monthly meetings to discuss and action governance requirements which applied to the service. This included reviews of incidents, complaints, scan reports, health and safety issues, delivery against business plan, information governance issues, what went well and what didn't go well.
- Checks and audits were carried out to assess the quality of the service provided to patients. However, not all areas of concern had been identified. For example staff were observed during the inspection to not comply fully with infection control procedures and did not consistently carry out robust checks to ensure the right patient had the right scan at the right time.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified some risks and issues and identified actions to reduce their

impact. However, there was not a full environmental risk assessment in place to identify risks to staff or patients. They had plans to cope with unexpected events.

- Risk assessments were completed regarding the service provided which identified potential risks such as legionella, fire, use of doors with internal locks, but there was no overarching environmental risk assessment. This meant actual risks were not always identified. For example, we saw a patient trolley which was awaiting collection that was partially blocking a fire exit. This was addressed immediately during our inspection.
- The registered manager had access to the organisational electronic risk register which could be used to identify specific risks at the service. This register was subject to an annual quality assurance review in support of a safe and effective service. Actions from the quality and risk report and other audits were monitored locally and at a corporate level. There were a number of risks identified on the register but these were mainly potential risks which staff were at risk from when working in the service. For example, back injuries, electric shocks, needle stick injuries, moving and handling equipment failures and spillages of radioactive material.
- Staff did not work alone during the times the centre was in operation. A lone working policy and procedure was in place to inform staff of the action to take to reduce the risks from lone working. However, staff did not always arrive or leave together which meant there were regularly times when one member of staff either opened or closed the building on their own.
- The service business continuity plan had been developed by the registered manager which included guidance for staff of the action to take in the event of electricity failure. The service was linked to the emergency generator supplied by the acute trust. Scenario training discussions took place at team meetings to prepare staff for such eventualities.
- Staff were informed regarding fire prevention and control within the service. On the day of the inspection firefighting equipment was being checked and serviced by an external organisation.
- Staff qualifications were checked during the recruitment process and reviewed annually to ensure clinicians were registered appropriately with their professional body. For example, the HCPC - Health and Care Professionals Council
- Staff wore dose badges and finger and eye exposure thermoluminescent dosimeter (TLDs). This is a type of radiation dosimeter. A measures ionizing radiation exposure by measuring the intensity of visible light emitted by a crystal inside the detector when the crystal is heated. The intensity of light emitted is dependent upon the radiation exposure. Staff were provided with the details from the dose badges and TLD by email so that they knew their exposure levels were safe.

Managing information

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

- Staff were provided with guidance to follow to ensure patient information remained safe and secure when sharing with others. For example, policies and procedures such as confidentiality code of conduct, data protection, info sharing guidelines and a personal identifiable data security policy. Staff had signed to say they had read and understood the policies.
- Computers were used to store electronic patient records and were secured by the use of passwords. We saw staff signed out of the computer when leaving the vicinity or the computer unattended.
- Paper records were scanned onto the electronic system and then securely shredded therefore protecting personal and confidential information.
- The service obtained consent from patients regarding their personal information and sharing with other organisations. The appointment details sent to each patient also included a consent to treatment form and a consent for storage of patient's details. This is in line with the General Data protection Regulation 2016. The

results and report produced were sent to the original clinical referrer only, requests for a copy by other parties would have to be made electronically and were assessed.

Engagement

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

- Patient satisfaction surveys were carried out with surveys available in the waiting room ready for completion. However, during our inspection, no patients were prompted to complete them. Staff told us electronic surveys were emailed to patients if appropriate, however there was no clear process for doing this. The registered manager stated surveys audited had showed patients were generally satisfied with the service provided. Completed surveys were entered onto the electronic system and the outcomes collated. There had been issues raised over the past year of appointments being delayed or cancelled although the comments showed patients were understanding of the reasons why. Patient feedback was shared with staff each month specific to the service they worked within.
- Staff meetings were held regularly and used as an opportunity for information sharing of information from the organisation and regional managers meetings. Minutes were maintained of the meetings and showed good attendance by the staff team. Issues discussed were recorded and actions identified the person responsible for completing together with a timescale. We did observe that the timescale was often identified as ASAP (as soon as possible) which is not a clear measure of time. We reviewed three sets of staff meeting minutes and say topics discussed included clinical issues, update information, staff issues and an opportunity for staff to discuss issues as they chose.
- A monthly newsletter was sent to each member of staff. The most recent newsletter provided an update of patient feedback across the organisation. This had included, a request for newer magazines in the waiting rooms, meet the staff team notice boards, eye masks to wear during scan and mirrors in changing rooms. The registered manager had reviewed the service against this information and was preparing to implement changes to respond positively to the feedback.
- Staff were requested to complete a survey every six months which was sent to individual staff members electronically.
- Staff were able to raise issues with the organisation through staff forum representatives who attended meetings with senior leaders. Feedback was shared from these meetings through newsletters and email.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

- Staff were supported to attend study days and conferences to develop their skills and practice.
- The service worked with external organisations to carry out research projects into new treatments and equipment.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff carry out appropriate checks to reduce the risk of the wrong patient undergoing the wrong treatment.

Action the provider SHOULD take to improve

- The provider should ensure that infection control policies and procedures were adhered to by all staff. In particular relating to hand hygiene and storage of cleaning materials.
- The provider should ensure the safety of patients and staff through the risk assessment process to include environmental risk assessments and ensuring equipment was ready to use.
- The provider should ensure that national legislation is fully complied with if care and treatment is not be delivered as expected or planned.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider must ensure that staff carry out appropriate checks to reduce the risk of the wrong patient undergoing the wrong treatment.

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.