

Turner Diagnostic Centre

Quality Report

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Website: www.alliancemedical.co.uk/scan-centres/turner-diagnostic-centre-colchester

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

Ratings

Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

Summary of findings

Letter from the Chief Inspector of Hospitals

Turner Diagnostic Centre is operated by Alliance Medical Limited. The service offers a range of diagnostic imaging procedures. Facilities include two magnetic resonance imaging (MRI) scanners and a positron emission tomography–computed tomography (PET-CT) scanner. Magnetic resonance imaging is a type of scan using magnetic fields and radio waves to produce detailed images of the body. Positron emission tomography–computed tomography uses radioactive material to obtain detailed images of the body to aid diagnosis of disease.

The service provides a diagnostic imaging service for patients aged 17 years and over who required a CT or PET-CT scan and MRI scanning (offered for patients aged 0+ years). We inspected diagnostic imaging.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 3 July 2019, along with a short notice announced visit to the centre on 9 July 2019 when a PET-CT clinic was in progress.

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

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

The only service provided by this centre was diagnostic and screening procedures.

Services we rate

This is the first time we have rated this service. We rated it as **Good** overall.

We found good practice in relation to diagnostic imaging:

- The service provided mandatory training to staff. Staff demonstrated compliance with mandatory training compliance rates.
- Staff understood and could describe actions to take to protect patients from abuse.
- The service controlled infection risk well.
- Staff completed and updated risk assessments for each patient.
- The service had enough staff with the right qualification to keep patients safe.
- Patient medical records were securely stored and accessible in a timely manner.
- The service reported and managed patient safety incidents well.
- The service provided care based on national guidance.
- Staff treated patients with compassion and kindness, whilst respecting their privacy and dignity.
- The service was planned and delivered in a way that met the needs of local people. People could access the service when they needed it.
- Leaders had the integrity, skills and abilities to run the service.
- The service had a vision for what it wanted to achieve and a strategy to turn it in to action.
- Staff felt respected, supported and valued. There was an open culture at the service.
- Leaders operated effective governance processes and worked collaboratively with other organisations.

However, we also found:

- Staff lacked knowledge around the meaning of the duty of candour.

Following this inspection, we told the provider that it should make three improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Summary of findings

Heidi Smoult

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Diagnostic imaging

Rating

Good



Summary of each main service

Turner Diagnostic Centre provides positron emission tomography and magnetic resonance imaging for NHS, private patients and self-funding patients. The service sees patients from Essex and surrounding areas. The service had sufficient suitably trained staff, was visibly clean, met the needs of local people and had effective governance systems and processes in place.

Summary of findings

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Good 

Turner Diagnostic Centre

Services we looked at

Diagnostic imaging

Summary of this inspection

Background to Turner Diagnostic Centre

Turner Diagnostic Centre is operated by Alliance Medical Limited. The service opened in 2002 and was previously called Alliance Medical Limited the 'Colchester Alliance MRI Unit'. The service became the Turner Diagnostic Centre in April 2018 and commenced seeing patients from a new, purpose build diagnostic centre. It is a private service in Colchester, Essex and also has contracts in

place to see NHS patients from the local area. The service primarily serves the communities of the East Suffolk, North Essex and surrounding areas. It also accepts patient referrals from outside this area.

The centre has had a registered manager in post since January 2011.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors and a specialist advisor with expertise in radiography. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Information about Turner Diagnostic Centre

The service has two magnetic resonance imaging scanners and one positron emission tomography-computed tomography scanner. It is registered to provide the following regulated activities:

- Diagnostic and screening procedures.

During the inspection, we visited the Turner Diagnostic Centre. We spoke with 10 members of staff including radiographers, reception staff, a consultant radiologist and senior managers. We spoke with two patients. During our inspection, we reviewed 14 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. The service has been inspected twice, and the most recent inspection took place in November 2013, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (1 March 2018 to 28 February 2019):

- In the reporting period 1 March 2018 to 28 February 2019, there were 18,154 scans (by number of scan areas) recorded at service; of these 74% were NHS-funded and 26% other funded.

The service employed 12 full time equivalent (FTE) radiographers (for magnetic resonance imaging and positron emission tomography-computed tomography (PET-CT) scanning). The service also employed seven FTE clinical assistants and seven FTE administrators.

There was no accountable officer for controlled drugs (CDs) as these medicines were not used by the service.

Track record on safety:

- Zero Never events
- Nine clinical incidents eight no harm, one low harm, zero moderate harm, zero severe harm, zero death
- Zero serious injuries
- Zero incidences of healthcare acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- Zero incidences of healthcare acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- Zero incidences of healthcare acquired Clostridium difficile (c.diff)
- Zero incidences of healthcare acquired E-Coli
- Nine complaints

Services accredited by a national body:

- ISO/IEC 27001 (information security standard)

Summary of this inspection

- Investors in People (standard for people management)
- The Quality Standard for Imaging (formerly the Imaging Services Accreditation Scheme (ISAS))
- Clinical and or non-clinical waste removal
- Resuscitation services
- Cleaning services.

Services provided at the hospital under service level agreement:

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as **Good** because:

- 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.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- 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.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm.
- 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 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, we also found the following issues that the service provider needs to improve:

- Out of three members of staff, two were unable to describe the meaning of the duty of candour.

Good



Are services effective?

We did not rate effective however, we found:

- The service provided care and treatment based on national guidance and evidence-based practice.

Summary of this inspection

- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- Staff worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven 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?

We rated caring 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.
- Patient satisfaction surveys and verbal feedback demonstrated that patients and their relatives had received a caring approach from the service.

Good



Are services responsive?

We rated responsive 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.
- 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.

Good



Are services well-led?

We rated well-led as **Good** because:

Good



Summary of this inspection

- 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. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, 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.
- 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.
- 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.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and staff development.





Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Diagnostic imaging

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Good 

Are diagnostic imaging services safe?

Good 

We rated safe as **good**.

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Staff received training in various subjects relevant to their role. Mandatory training was a mixture of face to face and e-Learning. Practical sessions included immediate life support and manual handling. The service's compliance target for mandatory training was 90%.
- The unit manager oversaw staff's compliance with mandatory training. At the time of our inspection, 99% of all staff had completed mandatory training.
- Staff received email notifications six weeks prior to mandatory training expiry to help ensure that training was completed within required timescales.
- Staff we spoke with told us they could access required training in a timely manner and were given time to complete training when required.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.**
- Staff had access to a paediatric safeguarding lead (level four) and adult safeguarding lead (level three) at provider wide level (Alliance Medical Limited).

- As of March 2019, 67% of staff involved in the care of patients under 18 years of age had completed safeguarding children level three training, 88% had completed safeguarding children level two training and 100% of staff had completed safeguarding children training level one. The service's target was mandatory training compliance was 90%. However, at the time of our inspection improvements had been made as 100% of eligible staff had completed safeguarding children level one and two training and 90% of eligible staff had completed safeguarding children level three training.
- As of March 2019, 100% of staff involved in the care of patients over 18 years of age had completed safeguarding adult level two training and 100% had completed safeguarding adult level one training. Staff had access to the provider wide adult safeguarding lead who was trained to level three.
- There were no safeguarding incidents reported to the Care Quality Commission between March 2018 and February 2019.
- The service had access to a provider wide safeguarding children policy and procedure and provider wide safeguarding adults policy and procedure. The documents were within their review period and outlined various types of child abuse to guide staff including female genital mutilation (FGM) and domestic abuse. The adult policy outlined other types of abuse including but not limited to; radicalisation, FGM, neglect and sexual abuse. Policies guided staff on how to escalate identified safeguarding concerns through a flow chart and telephone numbers for safeguarding leads within the service. Documents clearly outlined the responsibilities of the unit manager in relation to ensuring staff were up to date with training, aware of local procedures and how to report safeguarding concerns.

Diagnostic imaging

- All staff could describe safeguarding escalation processes and give examples of the signs of potential abuse. Staff described cohesive working with the local NHS and shared safeguarding referral information in line with policy.
- Safeguarding flowcharts and escalation information was available at regular intervals throughout the service.

Cleanliness, infection control and hygiene

- **The service mostly controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- During our inspection, we saw the majority of clinical and non-clinical areas were visibly clean. Areas included, but were not limited to; public waiting areas, preparation rooms, magnetic resonance imaging (MRI) rooms, the positron emission tomography room (PET), and changing rooms.
- Hand cleansing gel was provided for both staff and visitors at regular intervals throughout the service.
- Disposable curtains were visibly clean and replaced on a regular basis.
- The service carried out infection prevention and control (IPC) audits. The annual audit results from October 2018 showed; 94% compliance. Various areas were noted for improvement, we saw that the registered manager oversaw improvement and implemented changes in a timely manner. Monthly IPC audits from January 2019 to June 2019, showed compliance ranged between 95% and 100%.
- Mandatory infection control training was provided and updated on a regular basis. The service had access to a provider wide (Alliance Medical Limited) infection control lead in the event that advice was required.
- Staff had access to a policy named 'infection prevention and control manual'. The document was within its review date and provided guidance to staff on various IPC related procedures including, but not limited to; clinical waste and sharps (needles) handling, isolation precautions and decontamination processes.
- We saw that all staff had arms bare below the elbow to help prevent and control the spread of infection.

- We observed staff washing their hands between patient contact as per the World Health Organisation's "Five Moments of Hand Hygiene" guidance. The service displayed posters showing the "Five moments of hand hygiene" to guide and direct staff.
- We observed staff cleaning equipment and clinical areas after each episode of patient care and using appropriate decontamination processes.
- Cleaning of the service's facilities was provided under service level agreement (SLA) from the local NHS Trust. The SLA was regularly reviewed and staff from Turner Diagnostic Centre met with trust staff on a monthly basis to discuss cleaning requirements. The agreement provided a member of cleaning staff to be on site between the hours of 7 am to 3.30pm Monday to Friday, every evening and at regular intervals over weekend opening.
- Personal protective equipment (PPE) was available in all clinical areas. PPE included, but was not limited to; gloves and aprons.
- At our unannounced inspection, the clean and dirty utility areas were cluttered with items being stored on the floor. This meant that we could not gain assurances that all areas had been cleaned to effectively prevent and control the spread of infection. We raised our concerns with a manager.
- At our second inspection, we saw all clinical and non-clinical areas were clutter free, enabling effective cleaning to take place. A member of staff had taken responsibility to ensure that this area remained clutter free which would be monitored through future audit.
- We found two oxygen masks that were open to air within preparation rooms meaning we were not assured if they were clean. We raised our concerns with staff who advised this was not normal practice and immediately removed, disposed of and replaced the equipment.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**
- The service was located in a purpose-built building, located within the grounds of an NHS hospital.
- Both clinical and non-clinical areas were well lit, free from clutter and spacious allowing free movement.

Diagnostic imaging

- Staff had access to a meeting room. This room was used to accommodate several purposes including face to face training, meetings and personal developmental reviews.
- Clinical and non-clinical waste disposal, resuscitation and cleaning services were provided under service level agreements (SLA) with the local NHS trust. The SLA was subject to regular review.
- Access to the MRI scanners and PET-CT scanning equipment rooms was restricted. The hot lab (for storage and dispensing of radioactive materials) was secure at all times during our inspection.
- Resuscitation equipment was checked by Turner Diagnostic Centre staff on a daily basis. Resuscitation equipment was tagged to indicate if equipment had been tampered with.
- We reviewed check sheets for resuscitation equipment within the service. Equipment had been checked on all days of clinic opening for the three months previous to our inspection. Equipment included but was not limited to; a defibrillator (used in cardiac arrest to restore abnormal heart rhythms), airway and circulation equipment and oxygen.
- First aid boxes were located at regular intervals throughout the service. We found all contents to be well organised and in date.
- Fire extinguishers were located at regular intervals and serviced in line with manufacturer's recommendations.
- The service maintained records of equipment maintenance and servicing. We saw records demonstrated that both MRI machines, PET-CT machine and other clinical equipment underwent regular maintenance in line with manufacturer's recommendations.
- Changing facilities were well organised and tidy. Facilities included a locker, seat, mirror and emergency call bell system.
- Preparation rooms used for cannulation and administration of radiopharmaceuticals were well organised, tidy and provided a comfortable seat for patients.
- Within one uptake room (an uptake room is a specially designed radiation shielded room used in magnetic resonance) the biohazard spill kit was out of date. We raised our concerns with staff who immediately replaced this item.
- A radioactive source for quality assurance was used with PET-CT (to test the machine). The source was stored in a locked contained, bolted to the floor. Staff explained there was also closed circuit television in all areas, direct oversight from the PET-CT control room and secure access to all areas with the PET-CT suite to prevent unauthorised access to the radioactive source. This was in line with The Health and safety Executive 'control of radioactive substances' guidance (ionising radiation protection series number eight).
- A radiation protection quality assurance visit was carried out in March 2018. One recommendation from this quality assurance was that a retractable barrier was put in place outside of the PET-CT room door. We saw this equipment had been installed, as per recommendations.
- Equipment was marked magnetic resonance (MR) safe or MR conditional to prevent unauthorised objects from entering the MR environment.
- Emergency call bells were available in clinical areas and patient changing rooms. Records demonstrated that call bells were checked on a regular basis.
- Sharps (needle) waste bins were securely assembled, dated, signed and within safe fill limits to prevent the risk of needlestick injury and spread of infection. Clinical waste bins were clearly identified using coloured bags and there was a dedicated radioactive waste bin which was secure.
- We saw that two MR conditional wheelchairs did not have visible service dates. However, electronic records demonstrated that the equipment had been serviced in line with manufacturer recommendations.
- As part of a previous equipment inspection, it was recommended that the CT scanner in the PET-CT unit required a new x-ray tube. We saw this maintenance had taken place within a timely manner.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient and removed or minimised risks.**
- Both reception and clinical staff confirmed patient details on arrival at the centre and prior to each examination.
- Prior to examination taking place, all patients completed a patient information document. This document contained various information including name, date of birth, allergies, date of last menstrual period/pregnancy status (if applicable) and the patient height/weight (also confirmed by clinical staff).
- Pregnancy information posters were displayed with clinical and non-clinical areas.

Diagnostic imaging

- Patient safety questionnaires gathered more information around the patient's renal function, hypersensitivities, and included checks to ensure safe practices for patients requiring the use of Hyoscine Butyl Bromide and Gadolinium. These medicines are used to slow gut movement and improve image quality when acquiring scans. This ensured that only patients safe to receive these medicines did so.
- Magnetic resonance safety checklists were in use for patients who were ventilated (requiring support with breathing). This helped to ensure that only equipment deemed safe was used within MR areas. Patients who were ventilated were escorted by an appropriately trained member of staff from the local trust.
- The service displayed 'pause and check' posters to remind staff of confirming patients details, scan details prior to examination. We saw staff carrying out checks during the course of our inspection.
- Prior to and after positron emission tomography-computed tomography (PET-CT) taking place, blood glucose levels were assessed in line with best practice (varying blood glucose levels can affect scan results).
- Local Rules summarised key working instructions intended to restrict exposure in areas where radiation is used. Local rules were available in the PET-CT department. Records demonstrated that staff had read and signed the local rules however, the document did not indicate who the magnetic safety expert or magnetic resonance responsible person was.
- In the event of medical emergency or patient collapse, staff summoned an emergency response from the NHS trust, located adjacent to the building by calling an internal cardiac arrest/medical emergency telephone number.
- Staff had access to a policy named 'management of medical emergencies' which outlined the steps to take in the event of medical emergency at both stand-alone centres and mobile units.
- We spoke with four staff around escalation of a deteriorating or collapsed patient. Staff were clear in escalation processes, detailing provision of immediate life support and contact with the local NHS trust resuscitation team (located on site).
- Staff described resuscitation scenarios which had taken place recently which was in line with the service's 'management of medical emergencies' policy. However, no scenarios had involved the removal of collapsed patient within either the MR or PET-CT scanner which can expose staff to different challenges such as environmental risks and procedures.
- Children requiring sedation for MRI were assessed and admitted by the local NHS trust's elective care unit. Children were referred to Turner Diagnostic centre for scanning and seen on Monday morning sessions only. Trust staff escorted children from the ward, accompanied by an immediate life support trained member of trust staff and continuously monitored. Staff had access to a standard operating procedure for the 'safe sedation of children' which was within review date. The service did not provide sedation for any children who were not admitted to the local NHS trust.
- The service had trained four staff in paediatric immediate life support. At least one member of staff was available at all times when the service saw children and young people. All staff (100%) were up to date with basic life support training (children and adults).
- The service had a standard operating procedure in place for escalating unexpected findings to the referring consultant. Staff could describe escalation processes and also advised they would contact the local NHS trust clinicians if further advice was required.
- Closed circuit television (CCTV) cameras covered all clinical and non-clinical areas. Reception staff monitored non-clinical areas. Radiographers and other clinical staff maintained oversight of CCTV in clinical areas, including access to both MRI scanners and the PET-CT scanner.
- Clear warning signs, lights and notices were in place to warn patients, visitors and staff of both magnetic and radioactive areas of risk within the service.
- Background radiation checks took place on a twice daily basis. We reviewed check sheets and saw that for two weeks before our visit, background checks had been carried out at regular and required intervals.
- The service had a radiation protection advisor (RPA) and medical physics expert (MPE) supplied through a service level agreement (SLA). There was a named radiation protection supervisor (RPS) on site. At the time of our inspection, the RPS had received training in June 2018 and was awaiting an annual update. This was in the process of being arranged through the unit manager and planned to take place in September 2019.
- Staff described the RPA as being accessible and supportive in the event that guidance was required.

Diagnostic imaging

- Staff exposure to radiation was monitored through use of dosimeters. We reviewed documentation which demonstrated staff exposure had been checked on a regular basis from June 2018 to May 2019.

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.**
- The service employed a variety of staff including but not limited to; radiographers, technicians, clinical assistants, administration and reception staff.
- Departmental leads were responsible for rota planning, dependent on the department within the service.
- The service adhered to the provider wide (Alliance Medical Limited) staffing levels, as outlined in the 'staffing requirements in support of a safe scanning pathway' document. This document outlined minimum staffing requirements for various areas of the service to ensure enough staff with the right qualifications for each modality of scanning.
- There was one vacancy for a clinical assistant within the service. This post was out to advert at the time of our inspection.

Medical staffing

- **The service had access to enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.**
- The service did not directly employ medical staff.
- Consultant radiologists who reported on NHS scans were employed by the local NHS trust.
- The service had four consultants who worked under practising privileges to report on images for non NHS trust patients (GP referrals/self-funding patients/private referrals). They worked on an ad-hoc basis, dependent on demand.
- Practising privileges (PPs) were reviewed at a company wide level (Alliance Medical Limited) however, the unit manager also showed us records demonstrating oversight of PPs at local level.

- Staff had access to an on-call consultant radiologist through the local NHS trust in the event of advice being required.

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.**
- Referral requests for scans were received electronically or in paper format. Administration staff managed all referrals and updated systems on a daily basis.
- We saw that all patient records were stored in a secure manner. When not in use, computer terminals were locked to prevent unauthorised access.
- We reviewed 10 patient records relating to MR scanning. In all records we saw a completed referral, suggested protocol for scanning, length of appointment and radiation dose had been recorded in all cases.
- We reviewed three records relating to PET-CT scanning. All records documented patient information, dietary and diabetic information, fluorodeoxyglucose doses (used in PET-CT), allergy status and other relevant clinical information.
- We saw that scan reports cross referenced previous relevant scan reports, where necessary.

Medicines

- **Medicines were managed and stored appropriately by the service.**
- The service did not store or administer controlled drugs (CDs).
- A dispensing lab within the positron emission tomography-computed tomography (PET-CT) scanning area housed automatic dispensing equipment. The weight and height of a patient was programmed in to the automatic machine to ensure the right dose of radiopharmaceuticals per individual patient. All radiopharmaceuticals were dispensed in a sealed unit and disposed of in dedicated sharps (needles) bins after use.
- Staff could access the provider wide Alliance medical Limited appointed pharmacy advisor in the event of requiring further guidance or advice. The service's registered manager was the lead for the safe and secure handling of medicines.

Diagnostic imaging

- Resuscitation medicines were stored securely in tagged resuscitation trolleys/bags. Staff had access to medicines to treat anaphylaxis (severe allergic reaction) and this equipment was located in easily accessible areas.
- We reviewed a sample of patient groups directives (PGDs) in use at Turner Diagnostic Centre. PGDs covered the use of a variety of medicines, included but not limited to; sodium chloride, Hyoscine Butyl Bromide and gadoteric acid. All PGDs were within indicated review dates.

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.**
- Staff used an electronic incident reporting system and received training in this process at the point of induction.
- Staff had access to a standard operating procedure (SOP) named 'incident reporting'. The SOP was within its review date and provided guidance to staff on incident reporting procedures and processes and actions to take after identification of an incident.
- There had been no reported never events from 1 March 2018 to 28 February 2019. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The service reported one serious incident from March 2018 to February 2019 relating to radiation. From March 2018 to February 2019, the service reported seven incidents relating to radiation protection. The serious incident related to a possible operational error by Alliance Medical staff whilst carrying out CT urograms. The root cause analysis concluded the incident severity as low. The incident was reported to The Care Quality Commission under Regulation eight of the ionising radiation (medical exposure) Regulations 2017. The RCA demonstrated clear recommendations based on findings, which was shared with staff.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires the 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. From 1 March 2018 to 28 February 2019 there had been no notification where the duty of candour was required (Alliance Medical policy stated that notifications were to be made in the event of moderate harm or above).

- We spoke with three staff about their knowledge of the duty of candour. Out of three staff, only one member could describe the meaning of this. However, the registered manager demonstrated sound knowledge and held overall responsibility for implementing the duty of candour.
- We spoke with five staff about incident reporting processes. All staff could describe incident reporting systems in line with service policy.
- Staff had access to a medical physics expert in the event of needing guidance for incidents involving Ionising Radiation (medical exposure).
- The service's unit manager had received training in root cause analysis. Root cause analysis investigations are used to determine how and why a patient safety incident has occurred. In addition, further advice could be sought from the provider - Alliance Medical Limited.

Are diagnostic imaging services effective?

We did not rate effective.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence-based practice.**
- The service provided care in line with the Administration of Radioactive Substances Advisory Committee (ARSAC) and Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).
- All policies, procedures and pathways were supplied at provider wide level (Alliance Medical Limited, AML). We saw that policies reflected national guidance, were in date and appropriate for the location where services were delivered.
- Policies were easily accessible to staff, in good order and demonstrated staff had signed to indicate policies had been read.

Diagnostic imaging

- National and local diagnostic reference levels (DRLs, dose levels used in medical radio-diagnostic practices) were clearly displayed within the positron emission tomography-computed tomography (PET-CT) area.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs.**
- Due to the nature of services provided and transient stay within the service, patients were not routinely provided with meals. However, hot and cold drinks were available in all areas and staff offered patients light refreshments (biscuits) after examination.

Pain relief

- **Staff in diagnostic imaging did not provide patients with pain relief. However, they made sure patients were as comfortable as possible when undertaking imaging services.**
- Due to the nature of service provided, pain relief was not routinely offered.
- Staff regularly checked patient comfort levels during scanning procedures.
- We saw that staff took time to ensure patients were as comfortable as possible prior to the commencement of scans. Staff used position devices such as blocks, to minimise any potential pain and discomfort.

Patient outcomes

- **Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**
- The service had been accredited under relevant clinical accreditation schemes. Accreditation had been gained for the following: ISO/IEC 27001 (information security standard), Investors in People (standard for people management) and The Quality Standard for Imaging (formerly the Imaging Services Accreditation Scheme (ISAS))
- The service monitored a variety of performance indicators on a regular basis. Areas monitored included, but were not limited to; patient satisfaction, reporting times, referral to scan times and mandatory training compliance.

- There was a clear audit programme in place. Local audits included but were not limited to; Magnetic resonance cholangiopancreatography (MRCP) image audits, shoulder image audits and PET-CT audits.
- MRCP audits were completed on a monthly basis. Audit data for March 2019 showed images were graded as three and four which were within acceptable limits. The auditor noted possible patient positioning issues. The audit showed that one to ones were being held with staff to ensure the patient was placed in the best position and also the adjustment of gating bellows was effectively taking place (gating bellows are equipment used within the MRI setting).
- PET-CT audits from May 2018 to April 2019 (rolling 12 months) examined 200 images. All reports were graded five with the exception of one image which was graded as three (images were scored one to five, with one and two being of unacceptable image quality).

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**
- Staff had yearly appraisals. At the time of our inspection, the appraisal process was undergoing a period of change to align with September to September timeframes. To compensate for this change, all staff had received a mid-year review, with appraisals being booked to take place in September 2019 for all staff in line with new processes.
- Cannulation audits were carried out locally to ensure staff demonstrated competency.
- Training sessions provided by the local NHS trust, were offered to staff. Staff were given the opportunity to attend study days and view presentations by trust doctors around specialist scanning areas.
- Staff described feeling developed in their role and described opportunities to extend skills in relevant areas.
- Developmental opportunities were available for both clinical and non-clinical staff. One administrative member of staff described being encouraged to complete a business qualification. A clinical assistant described that the service had been supportive with them achieving further skills in cannulation.

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- Opportunities for learning and development were displayed within staff restroom areas. A radiographer described feeling supported in attending a neurological workshop, provided by Alliance Medical Limited.
- Professional registration (where applicable) were checked on a regular basis. We saw records that demonstrated all staff had the required registration in place and that it had been checked on a regular basis including consultant radiologist who provided image reporting services.
- Alliance Medical Limited provided human resources and induction support for new staff. All staff we spoke with described receiving a thorough and meaningful induction period with further support locally upon commencement of role. The provider wide induction policy was in date and provided guidance for staff on induction process and requirements.
- Staff had access to a policy for staff working under practising privileges. The document provided guidance for staff regarding the application and granting of practising privileges for staff who carried out reporting of diagnostic images.
- The service rarely used bank and agency staff. The Alliance Medical Limited training needs analysis, completed in September 2018 outlined the required level of training, dependent on role prior to working at the service.

Multidisciplinary working

- **Staff from various roles worked together as a team to benefit patients. They supported each other to provide good care.**
- We saw effective multidisciplinary team working between Turner Diagnostic centre staff of all grades. In addition, we saw effective team working with staff from the local NHS trust when carrying out a scan on an inpatient.
- Staff from Turner Diagnostic Centre met with the local NHS Trust service and radiology managers on a regular basis to oversee service provision.
- Staff worked with local NHS trust staff to provide various services such as waste management, cleaning and resuscitation services.

Seven-day services

- **Services were available seven days a week to support timely patient care.**

- The centre was open seven days a week. Monday to Friday 7.30am to 8.30pm for magnetic resonance imaging. The positron emission tomography-computed tomography (PET-CT) scanning department was open three days per week from 7.30am to 7.30pm. This provided flexibility in appointment times for patients.

Health promotion

- The service did not offer health promotion information due to the nature of scanning only services provided.

Consent and Mental Capacity Act

- **Staff supported patients to make informed decisions about their care. They followed service policy and procedures when a patient could not give consent.**
- We reviewed 10 medical records. All records demonstrated that written consent had been obtained prior to examination taking place.
- Staff had access to a policy named 'consent'. This provided guidance to staff on decision making and the Mental capacity Act 2005. The policy was within its review date
- Staff understood their responsibilities to obtain and document consent prior to examinations taking place.

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.**
- We saw staff introduced themselves by name and wore 'hello my name is' badges.
- Throughout our inspection, we heard and observed staff speaking with patients and visitors in a kind, respectful and caring manner both in person and on the telephone.
- Patients were escorted to clinical areas. Sensitive discussions and invasive procedures, such as cannulation, took place in areas that respected a patients privacy and dignity.

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- We saw that staff used blankets to maintain patient modesty and curtains to protect privacy.
- In the PET-CT department, we saw that staff routinely used a blind to respect patients privacy and dignity when preparing for a scan and getting changed afterwards.
- All patients we spoke with described being treated in a caring and compassionate manner.
- From 1 January 2019 to 30 June 2019, the service received 961 completed patient satisfaction questionnaires. Data showed that 94% of patients were 'satisfied' or 'very satisfied' with the care they had received.

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress.**
- Staff described how they would reassure anxious or frightened patients. A section on the patient information form gave patients the chance to note down any concerns around anxiety that they may have.
- For example, staff told us they would familiarise patients with the scanning room prior to examinations being carried out, provide ear plugs to minimise audio distress, eye masks and gently explain to patients the processes involved with scanning.
- There were several posters located throughout the department offering chaperones. Staff advised that if a patient requested to be scanned by a specific gender of staff, they would facilitate this request if possible. If not, another appointment would be offered.
- Staff described examples of continuity in care when as they got to know some patients who attended the service on a more regular basis.

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.**
- Patient and relatives told us they received adequate information about their scan prior to attendance at the clinic. In addition, relatives and loved ones were welcomed to discuss scanning procedures with staff (with patient consent).

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 offered wide flexibility in appointments times including early morning, late evening and weekend appointments. In addition, at periods of high demand, a mobile magnetic resonance unit was available to meet capacity requirements. In addition, extra appointments were offered in PET-CT when more capacity was required.
- NHS referrals were marked as 'routine', 'urgent' or 'most urgent' by the healthcare professional requesting the referral. Routine referrals were scheduled to be seen within four to six weeks, urgent within two weeks and most urgent were scheduled within five working days.
- Private referrals were scheduled within two weeks of referral. Patients also had the option of reduced fees for appointments that were provided over the two week period.
- The premises had been purpose built and were appropriate for the delivery of service provided.
- The Turner Diagnostic Centre was located within the grounds of an NHS hospital trust, provided access to car parking, public transport links and other healthcare related services. All areas were accessible to wheelchair users (with exception of the magnetic resonance unit – specialist equipment was required in the area for safety reasons).
- Both staff and patients accessed the building through a public entrance. All clinical areas within the building were restricted to authorised personnel only. Electronic codes restricting access were changed on a regular basis, and after a member of staff left the service to ensure security was upheld.

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- Accessible toilets were available in public waiting areas. The reception desk had a hearing induction loop in place to assist patients with hearing impairment. The reception desk was at varying heights to provide access to visitors with mobility needs.
- All patient areas were located on the ground floor and therefore accessible to those with additional mobility needs.
- The service provided NHS scans, through referral from the local NHS trust and GPs within the area. Private and self-funding patients were also referred to the service.
- Prior to scanning, a contact telephone number was provided for patients to call if they had any questions about their upcoming appointment.
- Prior to scanning, patient received information through the post outlining what to expect when they attended for a scan.

Meeting people's individual needs

- **The service took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**
- The service had access to translation services and interpreters could be booked upon request.
- Whilst staff did not receive specific chaperone training, staff could describe the role of a chaperone and facilitate this service at the patient's request.
- Appointment times were tailored by radiographers to ensure an adequate length of appointment. This gave patients a chance to ask questions about scanning processes if required.
- Scanning equipment could accommodate bariatric patients weighing up to 227kg (35 stone). Referral information contained information about a patient's weight to enable staff to forward plan in the event of caring for bariatric patients.
- Inpatients from the local NHS trust were accompanied by trust staff. Access to the unit was through an internal access point from the main hospital.
- Staff received training in dementia awareness to enable them to support patients with additional or complex needs.
- The service provided disabled toilet facilities. In addition, long handled shoe horns were available to aid footwear removal outside the magnetic resonance imaging unit.

- The Alliance Medical Limited website provided a wide range of information relating to various types of scanning procedures including contact details for the service.

Access and flow

- **People could access the service when they needed it and received the right care promptly.**
- The service offered magnetic resonance imaging (MRI) and positron emission tomography-computed tomography (PET-CT) scans in a timely manner from receipt of referral in line with internal key performance indicators. From July 2018 to June 2019, 109 patients were not scanned within recommended timeframes. Overall, this related to 1.7% of patients.
- From 1 January 2019 to 30 June 2019 the service had 15 breaches where patients did not receive a PET-CT scan within the recommended timeframe. Overall, this related to 1.6% of PET-CT appointments.
- Access to the service was monitored on a daily basis by administrative staff and the unit manager. Referrals were received, processed and allocated an appointment in a timely manner.
- We reviewed the records of 10 referrals. All cases were routine scans which were required to be scanned within four to six weeks. All patients were referred and seen for scanning in under six weeks in line with key performance indicators (KPIs).
- The unit manager monitored rates of patient that did not attend (DNA). Staff carried out reminder phone calls the day prior to scanning to avoid missed appointments. Patient who DNA were contacted and offered another appointment. Contact was made with the initial referrer for patients who failed to turn up three times.
- Staff described challenges around encouraging patients to attend appointments. For example, on 2 July 2019, three patients DNA despite receiving telephone reminder calls the day before. We saw evidence that reminder calls had taken place as these were documented on patient records.
- Self-referring patients could request an appointment via the Alliance Medical Limited website or through telephone if required.

Learning from complaints and concerns

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- **The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.**
- There were systems and processes in place to allow people to provide feedback and raise concerns about their experience of the service.
- Patients could feedback verbally, by post or through the service's website.
- From 1 March 2018 to 28 February 2019 the service received nine complaints, of which six were upheld.
- Common themes included a delay in appointment time. The registered manager told us that since these complaints, improved communication was in place between staff to ensure that patients were kept up to date with waiting times. In addition, at the time of our inspection, the service were in the process of implementing an information board to inform patients where there were expected delays to scans. We saw that staff kept waiting patients up to date during our inspection.
- The service previously received negative feedback about uncomfortable patient couches within the PET-CT suite. In response to complaints, the supplier of couches had changed. This led to no future complaints being received around patient comfort.
- At the time of our inspection, the registered manager was in the process of developing a 'you said, we did' information board to show patients and visitors where changes had been made because of feedback or complaints.
- The 'management of concerns and complaints' policy and procedure provided staff with timeframes acknowledging and responding to complaints.

- All staff told us that the unit manager was supportive, approachable and keen to develop staff of various grades within the service.
- During our inspection, we saw both the unit manager and administration manager maintaining a visible presence and offering support to staff. Local managers within the service described feeling supported by their managers at provider level (Alliance Medical Limited).
- There was a clear leadership structure in place. The Turner Diagnostic Centre was led by a unit manager, who in turn reported to the Alliance Medical Limited regional lead for magnetic resonance imaging (MRI) and head for positron emission tomography-computed tomography scanning (PET-CT). Locally, the PET-CT and MRI department leads reported to the unit manager.
- Staff at the service described feeling supported by managers and were clear on the leadership structures in place.

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 service had clear provider-wide (AML, Alliance Medical Limited) values in place. The provider wide mission statement was 'to support people and partners through the healthcare pathway to enable them to seize life's opportunities and improve life expectancy'. The AML 'strategy wheel' summarised the company's values, strategy and mission statement.
- Staff could describe the service's values, which were; openness, excellence, efficiency, learning and collaboration. Company value and vision information was displayed at regular intervals throughout the service.
- We saw evidence of collaborative working with the local NHS trust through regular meetings to assess and improve service provision. The service provided development and learning opportunities for staff. Staff were passionate about providing high quality, patient centred care whilst demonstrating compassion, dignity and respect – in line with the company's values.

Are diagnostic imaging services well-led?

Good 

We rated well-led as **good**.

Leadership

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

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Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.**
- Staff described a positive culture. All staff we spoke with told us they felt valued, supported and able to raise concerns if required.
- All staff described a positive atmosphere, supported by effective teamwork whilst demonstrating respect for one another. One member of staff described the service as 'very welcoming, friendly and brilliant'.
- We spoke with one consultant radiologist who reported on images for private patients seen at Turner Diagnostic Centre. They described a positive culture, supportive management and leadership within the service, that they 'enjoyed working there' and staff worked well as a team.
- We were provided with an example of where staff had gone above and beyond in the PET-CT department. Their work had been recognised by the unit manager who nominated staff for a reward. Staff received shopping vouchers and thanks to show appreciation of their work.

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.**
- Locally, service governance was overseen by the unit manager. There were Alliance Medical Limited governance systems and processes in place which supported local governance lead.
- Clinical governance meetings (AML wide) took place on a bi-monthly basis. Leads from these meetings fed back any issues or concerns to local leaders. We reviewed meetings minutes from January 2019 which demonstrated a broad range of discussion taking place around concerns, complaints, areas of learning, policy and sub-committee updates.
- Services provided through service level agreement (SLA) were monitored and discussed on a regular basis. SLA's were in place for waste management, cleaning and resuscitation services.

- Monthly contract review meetings discussed service provision in relation to the local NHS trust.
- Locally, staff meetings took place on a regular basis (for both radiographers and PET-CT staff). Minutes demonstrated a standard agenda and discussion around a number of subjects including but not limited to; incident reporting and feedback, image quality and staff competency assessments and developmental opportunities. meetings were well attended by a broad range of staff.
- Staff at all levels were clear on their roles and associated responsibilities.
- We saw that SLA's for radiation protection advisors and medical physics quality assurance were in date and regularly reviewed.
- All staff were subject to a disclosure and barring service (DBS) check upon commencement of employment. We saw all staff had received a DBS check.
- The service monitored reporting and appointment times in line with the AML radiology reporting policy. The policy was within review date and outlined clear responsibilities for staff.

Managing risks, issues and performance

- **Leaders 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.**
- Locally, leaders had oversight of risk the service may face. Areas of risk were escalated to Alliance Medical Limited quality and risk manager.
- Managerial staff had access to a company wide (Alliance Medical Limited) corporate risk register. Locally, risk assessments were in place to monitor and review risks the service may face.
- At the time of our inspection, the registered manager advised that a local risk register was in the process of development. The service submitted the risk register within two weeks following our inspection. The risk register covered a number of risks the service may have faced including but not limited to; emergency access to the PET-CT scanning room, manual handling risks and patient evacuation from clinical areas.
- The service had a business continuity plan in place, relating to service provision at Turner Diagnostic Centre. The plan clearly outlined escalation processes in the event of an incident that threatened business

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continuity. Action plans provided guidance for various incidents including but not limited to; scanner breakdown, loss of staff, loss of information technology systems and loss of power supply.

- Provider wide, Alliance Medical Limited (AML) compiled and shared monthly bulletins named 'risky business' to locations within the group. We saw recent copies of 'risky business' displayed in staff rest areas. The bulletin shared information about incidents, complaints and service related guidance to increase staff's understanding of risk.
- Provider wide, AML carried out quality assurance reviewed on a number of areas including; information governance, risk management and clinical care to assess for compliance against company wide policies and procedures. We reviewed details of a quality assurance review which took place in October 2018. Compliance was noted as the service having two issues with 'major non-conformity (delay in AML medical consumables supply chain and the use of non-sterile dressings being used during cannula removal in MRI). The review documented clear action and timescales to make required changes.

Managing information

- **The service collected 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.**
- Staff met on a regular basis to analyse service information and data to drive improvements.
- The audit schedule enabled staff to detect areas for improvement within the service. We saw that audit outcomes, complaints information and patient feedback was used to improve the service for patients.
- The service managed patient information in line with relevant legislation (General Data Protection Regulations (GDPR)).
- Staff received information governance was included as part of mandatory training.

- Medical records were stored in a safe, secure and accessible manner.

Engagement

- **Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**
- There were various systems and processes in place to maintain effective lines of engagement with staff. The unit manager had an open door policy. Staff were kept up to date through email communication, face to face meetings and notice boards with staff rest room areas.
- The service regularly engaged with the local NHS trust to monitor appointment times and service provision and quality.
- Staff meetings took place on a regular basis for both radiographer staff and PET staff.
- Staff engaged with local people when designing the building's interior. The engaged with a local artist who provided art work for patient facing areas.

Learning, continuous improvement and innovation

- **All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and the development of staff.**
- The service was provided from a purpose built facilities. At the time of design, staff were keen to future proof the building and factored in space to accommodate an additional MR scanner. Although no date had been formally set, the registered manager was keen to grow the service with an additional scanner over the next 12 months.
- The unit manager was passionate about growing the service. At the time of our inspection, they outlined ideas that in the future the unit could become involved with research. However, at the time of our inspection, no date had been set for this.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that staff are aware of the duty of candour.
- The provider should ensure that clinical and non-clinical areas are clutter free to enable effective cleaning to take place.
- The provider should ensure there are systems and processes in place to enable staff access to contact details for the magnetic safety expert or magnetic resonance responsible person.