

# Brighton and Sussex Medical School Clinical Imaging Science Centre

## Quality Report

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

## 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

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

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

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

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

# Summary of findings

## Letter from the Chief Inspector of Hospitals

The Clinical Imaging Science Centre (CISC) is operated by Brighton and Sussex Medical School Imaging Science Center and is located at the University of Sussex campus. The service aims to provide high quality Positron Emission Tomography (PET), Computed Tomography (CT), and Magnetic Resonance Imaging (MRI) imaging services. CISC provides diagnostic scanning services to the National Health Service (NHS), as well as commissioning private contracts. The service, operates as a joint venture partnership between the Universities of Sussex and Brighton and aims to facilitate research and innovative teaching. The centre does not undertake any image reporting. All images are transferred to the reporting radiologists and neurologists working in neighboring trusts.

We inspected this service using our comprehensive diagnostic inspection methodology. We carried out an unannounced inspection on 6th September 2018.

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

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

### Services we rate

We rated it as Good overall.

We found good practice in relation to Diagnostic Imaging:

- The provider ensured that patients had their health needs risk assessed before using the service.
- They used control measures to prevent the spread of infection and followed best practice guidance.
- MRI specific equipment was available for patient procedures. Equipment was well maintained and tested yearly.
- Patients were treated and cared for by kind, compassionate, competent staff.
- There were systems and processes to make sure that the service monitored and reviewed its performance and patient outcomes.
- We found systems and process which took account of patients' feedback and complaints. This feedback was used to improve patient experience and service delivery.
- Patients' could access the service within a reasonable time frame.
- We found the staff had a motivated and cohesive approach to delivering care.
- Staff felt well supported and described the leadership team as approachable and visible.
- There was a risk register which was regularly reviewed, and took account of challenges the service faced.

We found areas of practice that require improvement:

- The service did not meet the needs of their young patients because there was no children's safeguarding policy.
- The infection control policy did not incorporate any quality monitoring process. For example, despite seeing staff apply best practice when caring for patients, there was no hand hygiene, environmental audits or equipment clearing logs to evidence this. The provider commenced a hand hygiene audit, in line with best practice guidance and legislation.
- Staff did not have access to Mental Capacity Act training, or manual handling training at the time of the inspection. However, this was rectified with immediate effect when identified.

**Amanda Stanford,**

Deputy Chief Inspector of Hospitals

# Summary of findings

## Overall summary

Brighton and Sussex Medical School is a joint venture in partnership with the University of Sussex. Services provided are diagnostic imaging in the fields of Positron

Emission Tomography/Computed Tomography (PET-CT and CT) and Magnetic Resonance Imaging (MRI) to patients from local National Health Services trusts and other locations.

# Summary of findings

## Our judgements about each of the main services

### Service

#### Diagnostic imaging

### Rating Summary of each main service

Good



We rated this service as good because it was safe, effective, caring, responsive and well-led. Patients were cared for by kind and compassionate staff who had a good understanding of how to meet individual care needs. Incidents and complaints were reported, investigated and learned from. Staff received the required level of training to manage emergency situations. The environment was visibly clean and tidy and staff followed best practice infection control guidance when caring for patients. Equipment was well maintained and tested regularly and serviced. Services were planned and delivered in a way which met the needs of the local population. Waiting times and cancellations were minimal and managed appropriately. There was a well-defined leadership structure and lines of accountability. The service had an open and transparent culture and staff were aware of their responsibilities to ensure compliance with the Duty of Candor regulations. However: The service did not meet the needs of their young patients because there was no children's safeguarding policy. The infection control policy did not incorporate any quality monitoring process. Staff did not have access to Mental Capacity Act, or manual handling training at the time of the inspection.

# Summary of findings

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Good



# Brighton and Sussex Medical School Clinical Imaging Science Centre

**Services we looked at**

Diagnostic Imaging Services;

# Summary of this inspection

## Background to Brighton and Sussex Medical School Clinical Imaging Science Centre

The Clinical Imaging Science Centre (CISC) was operated by Brighton and Sussex Medical School Imaging Science Center and in collaboration with two local universities. The service opened in October 2007. It had an independent imaging service located on the University of Sussex Campus, in Brighton. Diagnostic imaging services are provided to the National Health Services, as well as to other independent health providers. The service aimed to provide high quality diagnostic imaging as well as research, educational and clinical development opportunities.

The centre had a main reception area where all patients and visitors report on arrival. Access to the centre was

controlled by video entry phone. The centre had three scanning rooms and two control rooms. The PET, CT & 1.5T scanners were situated in the East Wing which had a combined control room. The West Wing had a 3T MRI scanner and had a dedicated control room.

There was an additional waiting area, an accessible toilet designed to accommodate people with physical disabilities, an emergency treatment area, a seminar room and additional bathroom and shower facility.

The service had the same registered manager in post since 2011.

## Our inspection team

The team that inspected the service consisted of one CQC inspector and one specialist advisor. The inspection was supervised by an inspection manager and overseen by Catherine Campbell, Head of Hospital Inspection-South East.

## Why we carried out this inspection

We carried out this inspection as part of our routine Diagnostic inspection programme.

## Information about Brighton and Sussex Medical School Clinical Imaging Science Centre

The centre was registered to provide the following regulated activity:

- Diagnostic and screening procedures.

During the inspection, we visited all clinical areas and the main reception area. We spoke with nine staff including; radiographers, nuclear medicine technologists, consultants, research fellows, reception staff, and senior

managers. We spoke with four patients and one relative. We also reviewed twenty-five comment cards which patients completed. During our inspection, we reviewed four 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 was last inspected in February 2014 which found that the service was meeting all the standards of quality and safety it was inspected against.



# Summary of this inspection

## Track record on safety

- No reported never events
- No serious incidents
- 5 Clinical incidents resulting in 5 low harm
- No duty of Candour notifications
- No incidents of hospital acquired infections
- No complaints within the inspection time frame

# 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:

- Staff had undertaken most of the mandatory training modules required to meet the needs of the service.
- Incidents were reported, investigated and used to prevent recurrence.
- Patients had their individual health risks assessed before using the service.
- Equipment was regularly checked and cleaned in line with best practice guidance.
- The environment was visibly clear and tidy.
- Records were safely stored and kept confidential.

However:

- The service did not meet the needs of their young patients because there was no children's safeguarding policy.
- The infection control policy did not incorporate any quality monitoring process.
- Staff did not have access to Mental Capacity Act, or manual handling training at the time of the inspection.

Good



### Are services effective?

We do not rate the effective domain, however

- Policies and procedures reflected evidenced based practice and were in line with recommendations from the National institute for Health and Care Excellence (NICE) and other national guidelines according to PET/MRI specialities.
- The provider ensured it measured performance and outcomes in line with contractual Key Performance Indicators (KPI).
- Staff were competent to do their jobs and were supported to gain additional skills.
- Patient consent was obtained in line with best practice guidance.

### Are services caring?

We rated caring as Good because:

- We saw staff being kind, considerate and caring toward patients and their relatives during the inspection.
- Despite the expected time pressures, staff treated patients with dignity and respect and gave them the time they needed to ask questions and give appropriate reassurance.

Good



# Summary of this inspection

- Patients were actively encouraged to provide feedback about their experiences and these were used to improve the service.
- Comments received by the service were overwhelmingly positive about the personalised approach and professionalism of all the staff.

## Are services responsive?

We rated responsive as Good because:

- Patients were provided sufficient amounts of information about the service and the procedure before attending.
- Staff took account of patient's individual needs.
- There was a system and process to take account of complaints and comments. Staff were aware of the process and able to provide the necessary support should a patient wish to make a complaint.

**Good**



## Are services well-led?





We rated well-led as Good because:

- There was a well-defined leadership structure with clear lines of accountability.
- Staff felt valued by their immediate line manager.
- The leadership team was visible, approachable and staff felt well supported.
- There was an active risk register and suitable governance system in operation
- Staff were engaged with the vision and strategy and committed to its delivery.

**Good**



# Diagnostic imaging

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Good 

## Are diagnostic imaging services safe?

Good 

We rated it as **good**.

### Mandatory training

- Staff in the service received the required amount of training to be able to undertake their roles and keep patients safe.
- Mandatory training was mainly provided on line, and compliance was recorded electronically and in paper form.
- Examples of the training provided included the following topics, fire health and safety, infection control, information governance, customer service, equality and diversity.
- A training lead had been introduced to ensure a single oversight of compliance rates and learning needs of staff. Training compliance targets was set at 100%.
- At the time of the inspection, all mandatory modules had been completed except for manual handling training. This module was booked and due to be completed by all staff by January 2019.

### Safeguarding

- The provider had systems and process in place, which were known to staff and used to protect adults from the risk of abuse. Staff demonstrated the right skills and knowledge to be able to safeguard its service users from abuse. Staff told inspectors how they would raise concerns and the actions that would be taken as a result of raising concerns.

- The provider had a safeguarding adults' policy which reflected national guidance and was easily accessible to staff. However, the service did not have a children's safeguarding policy.
- Staff received level two safeguarding training which was delivered as an annual online training package. One-hundred percent of staff had completed level one and two safeguarding training.
- The providers Statement of Purpose and business contracts specify the service can meet the need of 17-year olds. We were provided with assurance that no 17-year olds used the service within the inspection time frame. However, the safeguarding intercollegiate document recognises 17-year olds as children. At the time of the inspection there was no staff member who had received level three safeguarding training. However, After the inspection we received confirmation that level three safeguarding training was provided to staff.
- There were no safeguarding concerns reported to CQC within the last twelve months.

### Cleanliness, infection control and hygiene

- Service users were protected against the risk of health acquired infections.
- We saw all staff apply best practice during the inspection. They were bare below the elbows, washed their hands in between patient contact, wore personal protective equipment (PPE) correctly, and cleaned and prepared equipment in line with the providers own policies and best practice. PPE can be defined as refers to protective designed to protect the wearer from injury or the spread of infection or illness.
- We saw appropriate waste disposal facilities. Sharps bins were signed and dated and clinical waste was managed in line with Health Technical Memorandum (HTM) 07-01.

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- We saw Infection control compliant sinks were available in-patient areas.
- The environment was visibly cleaned to a high standard. The service had a regular cleaner who was not employed directly by the service but was embedded into the team.
- The provider carried out an independent yearly audit of infection prevention and control in the service. This audit included the quality of infection prevention and control clinical practice as well as the condition of the environment. The last infection control audit was carried out in July 2018, and found the service was 97% compliant. However, the frequency of this audit only provides assurance that the environment meets the standards once a year. There was no system to ensure compliance was continuously monitored, and trends and themes identified.
- There was an appropriate Infection Prevention and Control policy which reflected best practice guidelines. We saw good standards of infection prevention and control being applied during the inspection, but the lack of a regular hand hygiene or equipment audits in the months before the inspection meant there was no evidence of a continuous application of national guidelines. This meant the provider was unable to monitor trends and themes to identify areas for improvement. We discussed this with the provider during the inspection. They were responsive to the feedback and have reinstated the equipment clearing audit. Staff told us the audit activity was disrupted during the period of contract renegotiation and was compounded by two members of staff leaving the service. This meant that staff had to prioritise clinical work over administration.
- We observed staff cleaning reusable medical equipment such as immobilisation forms and radiofrequency coils (radiofrequency coils are essential for producing high quality images). They used disinfectant wipes after every use. However, there were no cleaning logs to evidence the continuous application of national guidance.
- Staff had access to and used single use disposable supplies. This included eye masks, and ear plugs. However, we noticed the tourniquet used was not disposable or wipeable. A tourniquet is a compression device used to stop the flow of blood through a vein or artery. This meant there was a small risk of cross contamination that was not being managed effectively.

## Environment and equipment

- The centre had a main reception area where all patients and visitors report on arrival. Access to the centre is controlled by video entry phone. The centre had three scanning rooms and two control rooms. The PET CT & 1.5T scanners was situated in the East Wing which had a combined control room. The West Wing had a 3T MRI scanner and a dedicated control room.
- We saw a dedicated password protected consumables cupboard. It appeared neat and tidy and all items were stored off the floor on dedicated shelves.
- An additional waiting area and emergency area were available, if required, and there was an accessible toilet designed to accommodate people with physical disabilities. There was also a seminar room, and additional bathroom with shower facilities.
- Patients were provided with individual rooms with handwashing facilities. Each cubicle had an emergency cord which was used to alert staff in the event of an emergency.
- Close Circuit Television (CCTV) was installed in each of the cubicles which staff could view from the central control room. This was in use to ensure all patients were safe whilst waiting for their scans. Patients were made aware of the use of the cameras on admission.
- The provider had allocated 'hot toilets' for patients considered radioactive, this reduced the risk of radioactive contamination to other patients. There was a second toilet available if more than one was needed for patients. The toilet had clear signage to prevent contamination.
- Areas where radioactive material was handled and stored was monitored by film badges. A film badge can be defined as a device containing photographic film which measures the wearer's exposure to radiation. This meant that the provider continuously monitored the levels of radioactivity on the premises to ensure the safe limits for patients and staff were not exceeded.
- Staff were provided with personal film badges and electronic personal devices which had an audio alert which increased its audio frequency when it detected radiation. This was a useful method of ensuring students and staff were continuously aware of their exposure to the radioactive substances. Staff badges were reviewed monthly to ensure staff had not exceeded the recommended exposure levels.

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- We saw evidence of the system and process used to monitor the risk of staff cross radioactive contamination. If this was identified, staff were isolated in the building until they were made safe. Staff had access to a spill kit in the event of a radioactive material. A spill kit is a collection of items used to handle minor radioactive spills and routine contamination problems.
- Levels of waste material were disposed of, logged and monitored weekly by the provider and reported to the University Health Radiation Protection Officer to make sure the safe limits set by the environmental agency were not exceeded.
- Staff provided a daily list for the cleaning staff daily, which identified areas as 'safe' to clean. This meant the risk of cross radioactive contamination was reduced.
- There was a dedicated resuscitation area which contained all the necessary equipment needed to manage emergency situations. For example, we saw a red transfer bag which contained equipment and consumables, oxygen and a positive pressure ventilation apparatus (which could be used if a patient stopped breathing). All items were found in date and we saw written evidence the bag was checked weekly, and or immediately after use.
- We reviewed the service level agreements which showed all the equipment used was monitored and serviced regularly. Maintenance logs were also available for each item of equipment.
- There was an effective system for recording faulty equipment. All fault/error messages (including those resolved by radiographers) were recorded in an electronic log to monitor trends. Messages were shared, reviewed, and discussed with service engineers and manufacturers.
- All the equipment available for use in the MRI suite was MRI safe. There was one trolley in the centre which was not MRI safe. This trolley was clearly labelled and stored in a safe area. Equipment deemed to be MRI safe was coloured blue to make it easily identifiable in line with the (MHRA) safety guidelines for magnetic resonance imaging equipment in clinical use (2015). MRI safe equipment is made from non-metal materials so not to interact with the magnetic field of the scanner.
- We reviewed the most recent fire risk assessment and found no outstanding actions. Fire extinguishers were available at various points through the building. They

were colour coded with a blue top to indicate they were MRI safe. All staff had received fire marshal training to ensure they had the skills necessary to deal with an unexpected fire.

- Access to restricted areas was well controlled with swipe card access. We found appropriate signage displayed outside of clinical areas to indicate rooms were in use and should not be entered.

## Assessing and responding to patient risk

- The provider had systems and processes to ensure individual risks were assessed and effectively managed. There was a dedicated MRI responsible person who took responsibility for the MRI safety in the centre. All staff (100%) received Intermediate Life Support (ILS) training and took part in emergency scenario simulation training yearly.
- The service received inpatient referrals from a local NHS trust. These patients had a risk assessment carried out by the radiographers to make sure the service could safely meet their needs. The service had a standardised proforma which asked questions related to pregnancy, pacemakers, shrapnel or metal. It also included the reason for referral, patients current condition, and any existing medical history. The availability of a nurse escort was included as a key criterion of acceptance.
- Patients considered 'high risk' of pregnancy were identified pre-admission and asked to complete a pregnancy test upon arrival. We saw an incident report which detailed a cancelled scan due to an inability to complete a pregnancy test. This demonstrated the service took account of the risk of pregnancy and managed it effectively.
- Patients given a contrast injection as part of their MRI procedure were instructed to stay within the unit for 15-20 minutes and monitored for any delayed reaction. Staff provided patients with post injection information detailing what agent had been administered and how to seek medical advice should a delayed reaction occur.
- All patients who presented for a scan had to fill out a safety questionnaire. Each form was reviewed together by the radiographers, and patient prior to any imaging procedure. The form asked questions to identify particular risks related to pregnancy, pacemakers, shrapnel or metal, previous scans and any other

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relevant medical history. Staff were observed reviewing the screening forms after completion and undertaking a systematic three-point check to confirm each patient's identity before a procedure.

- During the inspection time frame, one patient who became short of breath after their scan, was transferred to the local NHS trust in line with the Service Level Agreement. This outlined the process to be followed should a patient's condition deteriorate and require medical attention.
- Fasting was essential for all PET CT procedures. Therefore, all patients received a blood glucose check prior to injection of the radioactive tracer. There was a standard process in place to monitor diabetic's glucose levels.
- The staff had an awareness of how radiation affected patients and did everything reasonably practical to minimise the dose to the patient. We saw all doses were formally recorded.

## Staffing

- The service had sufficient numbers of staff who had the appropriate pre-employment checks undertaken before starting work. The service followed a local staffing standard to make sure there was always two radiographers allocated to each scanner.
- The recent renegotiation of the National PET CT Procurement process, and a new contract with an independent provider, had resulted in delays in advertising for additional staff. There was a period of uncertainty which had an impact on the providers ability to recruit more staff. However, at the time of the inspection, two new staff had been recruited, and the service had advertised for four additional radiographers to join the team. Interviews were scheduled for October 2018.
- The staff worked flexibly and opted to work additional hours to ensure the needs of the service was met during the recruitment phase. The service used agency cover to backfill when staffing gaps were identified.
- All staff were subjected to the appropriate pre-employment checks, and all staff had received an enhanced Disclosure and Barring service (DBS) checks. Staff had the relevant qualifications and reference reviews before starting work.

## Medical staffing

- Dedicated medical cover was provided between 8am and 5pm daily by a General Medical Council (GMC) registered professional. This was mainly provided by one member of staff who had backup support from the Nuclear Medicine consultants at the local trust.
- It was recognised that the provision of medical cover would need to be extended to two staff, given the re-negotiation of recent contracts and the plan to extend the opening hours.
- On rare occasions where cover was unable to be provided, there was a backup system to employ locum staff. No locum staff had been used within the inspection time frame.

## Records

- The service used an electronic Radiology Information System (RIS) records management system. Medical records were stored securely and kept confidential.
- We reviewed four sets of records and found that they contained all the required information. This included completed consent forms and relevant checks. All records were accurate, complete, and stored securely.
- Referrals were accepted from two local NHS trust, GP's, and from research programmes. Referrals were sent electronically to the service and were initially processed by the administration team and then reviewed by a member of the clinical team.

## Medicines

- Medicines and contrast were stored, handled and disposed of, in line with national guidance. Nuclear medicine was stored securely, shielded labelled and disposed of in line with best practice guidance.
- The service had a clinical lead for medicine management and a Standard Level Agreement with the pharmacy department in the local trust to provide additional support and advice. No controlled drugs were stored at the centre.
- Staff used Patient Group Directions (PGD's). Patient group directions allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription.
- Medications covered in the PGD's included dispersible aspirin, glycerol trinitrate spray and tablets, oxygen, glucose gel, salbutamol inhaler and radiographic contrast media. These directives were developed in line with healthcare professionals from the local trust and service staff. Staff were assessed to ensure they were



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competent to administer these medications. We reviewed a sample of PGDs and saw they were in date and in line with National Institute for Health Care Excellence (NICE) guidance. There was a set process to review PGD's in line with the local trust protocols.

- We saw allergies were documented on referral forms. Patients were asked about their allergies, as part of the routine checks in line best practice guidance, prior to any medication or contrast being administered.
- The provider had a valid Administration of Radioactive Substances Advisory Committee (ARSAC). This licence must be obtained to carry out research-indicated nuclear medicine procedures.

## Incidents

- The provider had systems and processes to make sure incidents were identified, reported, investigated and learned from. There was an incident reporting policy which provided guidance for staff on how to raise a concern and outlined the process of investigation. This included guidance on sharing information about incidents with the patient and the referrer.
- Staff we talked with told inspectors how the incident reporting system worked and provided evidence of learning from incidents reported in the past. Learning from incidents was discussed as part of staff meetings. Staff told us the size of the team supported a timely and effective feedback. Learning from such incidents were discussed at staff meetings.
- We were provided with an example of a low-level incident where a patient tripped on a paving stone on the way to their appointment. The incident was documented on the internal incident reporting system and a copy was sent to the referrer. It was escalated to the estates management team who took immediate action, and replaced the paving stone within 24 hours of the report.
- The number of incidents reported were low. The recorded risk and impact to patients was also low. The service did not report any never events in the 12 months prior to our inspection. Incidents information was reviewed to identify trends and themes quarterly by the service manager and business director before escalation to the governance committee.
- There were five incidents reported within the inspection time frame. These included two low blood sugars, two episodes of breathlessness and one fall.

- There were no serious incidents which required notification during the reporting period. We saw evidence the service was aware of their responsibility to notify CQC and the Health and Safety Executive. Whilst the evidence we received was outside the inspection time frame, it was clear the provider and staff were aware of their responsibilities to report serious incidents to CQC and other bodies.

## Are diagnostic imaging services effective?

We do not rate the effective domain.

## Evidence-based care and treatment

- The service provided care and treatment based on national guidance.
- Policies and procedures used in the service followed evidence based practice and were developed in line with the health and care professions council (HCPC) standards of proficiency for radiographers. These standards set out safe and effective practice in the Radiography profession.
- They also reflected the medicines and healthcare products regulatory agency (MHRA) safety guidelines for magnetic resonance imaging equipment in clinical use (2015).
- Policies also reflected the National Institute for Health and Care Excellence (NICE) guidelines. For example, staff in the MRI unit followed the NICE guidelines to minimise the risk of contrast induced acute kidney failure by ensuring blood test results were available within the desired criteria before proceeding the scan.
- Staff reviewed each referral for examination to ensure it was appropriate to the patients care and in line with The National Institute for Health and Care Excellence (NICE) guidance, iRefer (RCR guidance).
- The service had an audit process and monitored the service quality against its own policies and standard operating procedures. This audit programme reflected local and national audit requirements and results were used to influence change. This demonstrated the care delivered was evidence based and regularly monitored to ensure it was meeting national guidelines and recommendations IRMA/MHRA reporting
- At the time of the inspection, the service had not achieved national accreditation. However, the centre



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commenced the process for achieving the Imaging Services Accreditation Scheme (ISACS). Whilst the service had commenced the auditing programme for accreditation the pace of this slowed due to waiting for the outcome of the National PET CT Procurement process. Accreditation is a quality assurance program for clinical images produced for clinical imaging.

## Nutrition and hydration

- Patients had their hydration and nutritional needs met by the service.
- Staff followed national guidance to make sure that patients were not left for long periods without adequate nutrition and or hydration. Fasting times were in line with national recommendations.
- Special dietary advice was provided to those who were diabetic or had other medical conditions.
- Where possible patients were encouraged to help themselves to fluids in the waiting room where there were two machines, which provided hot and cold drinks.

## Pain relief

- Analgesia was not provided to patients during their treatment. Patients were not routinely asked about their pain levels. Due to the nature of the service, it was expected patients self-manage their pain prior to their appointments.
- However, if a patient expressed concerns about pain, this was assessed on an individual basis and staff provided guidance and support to manage the situation accordingly.

## Patient outcomes

- The service monitored the effectiveness of care and treatment and used the findings to improve the service provided.
- The service monitored its performance and patient outcomes against its contractual KPI's (Key Performance Indicators). Areas measured included, but were not restricted to: completion of experience surveys, clinical satisfaction, availability of previous images, delivery failure, image quality, clinical and non-clinical cancellations, injected tracer scan failure. Performance was reported quarterly to the board leadership as well as the local trusts who commission the service. Data reviewed showed compliance with all Key Performance Indicators.

- The quality of the work undertaken by the service was reviewed at a formal 'discrepancies' meeting. Reviewing and learning from reporting discrepancies, which may arise with the was in line with the Royal College of Radiologists: Standards for learning from discrepancies meetings guidance.
- There were audits which measured patient waiting times, Multi-Disciplinary Team (MDT) and external provider satisfaction with the quality of images.
- The service was not identified as a CQC outlier in any areas. The term 'outlier' can be used to describe a service that lies outside the normal.

## Competent staff

- The service made sure staff were competent to work in the service.
- Patients were cared for by staff with the right knowledge, experience and qualifications to support their needs. Staff were encouraged to gain additional skills and qualifications relevant to their positions.
- Staff competency assessments were in place across the service. We saw competency being assessed during our inspection. Staff told us they were supported to actively seek learning and development opportunities to develop in their role.
- All staff had annual yearly appraisal to make sure their learning and development needs were discussed with their line manager. We reviewed a sample of two appraisal documents which showed open and honest conversations about learning and development.
- Records showed that staff were trained in MRI/PET safety level responsibilities relating to the use of all equipment.
- All staff had received intermediate life support training. The provider ensured all staff had emergency simulation training on annual yearly basis. This meant that all staff had the skills necessary to manage an emergency.
- New and locum staff had a local induction (which included a competency assessment) to the services policies and procedures. Their performance was consistently reviewed by established staff during a probationary three-month period to ensure competence. Professional support and opportunities to learn and develop were provided by the team during the working day. We saw the team provide oversight and support to locum staff during the inspection.

## Multidisciplinary working

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- During the inspection we saw care being delivered by a multidisciplinary team. This included input from radiologists, nuclear technicians, consultant's, researchers, and students.
- There were good links to the local NHS trusts consultant body, referring GP's and both local universities. The clinical lead was a consultant working at the local trust which resulted in a positive working relationship.
- The diagnostic images produced by the service were reviewed in the weekly multidisciplinary team meetings at the local trusts. Any concern with the image quality was reported directly to the service. However, there were no concerns raised within the last twelve months.
- All staff we spoke with said they had access to medical staff and could discuss patient-related concerns with them.

## Seven-day services

- The service was provided between 8am and 5.30pm daily, Monday to Friday. The reviewed vision and strategy for the service will see the service extend it's working hours to 7pm in the coming months.

## Consent and Mental Capacity Act

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental health conditions and those who lacked the capacity to make decisions about their care.
- The service had a Mental Capacity Act (MCA) policy. The policy set out procedures staff should follow if a person lacked capacity.
- At the time of the inspection Mental capacity training was not provided to staff. However, staff we spoke with could describe how mental capacity was assessed and could identify when it would be appropriate to test a patient's capacity. Staff also told us they understood the principle of assessing capacity and best interest decisions but they had not had to apply this knowledge. We raised this with the provider during the inspection and have received confirmation that Mental Capacity training will be provided to all staff.
- On the day of inspection we saw patients give informed consent before a scan was undertaken. This was verbally confirmed during the patient pre-scan information review process and was form completed by the patient and a radiographer/nuclear medicine technologist, prior to imaging.

- One member of staff had received dementia training. This staff member was the dementia lead that provided the team with specialist advice and support when needed.

## Are diagnostic imaging services caring?

Good 

We rated it as **good**.

## Compassionate care

- Staff cared for patients with kindness and compassion.
- We observed staff being friendly and professional during their interactions with patients. We also saw staff attending to relatives with a caring attitude, which showed an inclusive approach to caring to all individuals who attended the centre.
- Feedback from patients confirmed that staff treated them well and with kindness. Comments we received on the day of inspection were positive.
- The four patients we talked with during the inspection were very complimentary. They told us staff were "kind", "caring", and "attentive". Patients felt the care they received reflected their personal beliefs and said staff respected their wishes.
- The interactions we observed between staff and patients were professional and compassionate. We saw the staff continuously check and communicate with patients in the private waiting area via the intercom which provided continuous reassurance during their procedures.
- Patients were actively encouraged to give feedback about their experience of using the service. We reviewed twenty-five comments collected during the inspection time frame. We found them to be largely positive. Comments received included: "first class service, well done all", "I do not feel you could improve the service, very helpful lovely staff", "I was very much at ease", "polite, professional and extremely helpful staff".
- The January 2018 to April 2018 patient survey results showed 100% (34 responses) reported feeling their privacy and dignity was respected. All the patients surveyed (100%) reported being happy with the amount of information given, and the helpfulness of centre staff.

## Emotional support

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- Staff provided emotional support to patients to minimise their distress.
- During the inspection we saw staff take time to interact with patients, giving them assurance and the emotional support they needed prior to their scans. Staff told us about how they managed patients who were anxious and claustrophobic. The staff approach to dealing this, was continuously commented on in the patients' survey.
- An example of the comments received included: "Well done CISC team, you made a potentially anxious situation a pleasure", "from the minute I entered the reception area, I was put at ease", "the lady who put me in the scanner also took away my anxiety".

## Understanding and involvement of patients and those close to them

- Patients and those close to them were involved in making decisions about their care.
- We observed giving patients the time they needed to answer questions about the procedures. Staff communicated with patients and their relatives in a way that they could understand. Patients were given sufficient time to ask questions, we observed this during the inspection.
- Staff were aware that the majority of patients attending for procedures had a diagnosis of cancer, which meant they recognised patients may have high levels of anxiety, fear, and felt unwell.
- The patients and relative we talked with told us they felt involved in their care and were given enough time, and information to understand what the procedure involved.
- Between January 2018 to April 2018 the patients survey returned 33 responses. It showed 100% of patients were happy with how they were treated by staff, and the amount of information they were given during their visit.
- Comments from the patient feedback questionnaire also confirmed this. An example of the comments received included "I kept fully informed", "it was all good, and I am profoundly deaf, thank you".

## Are diagnostic imaging services responsive?

Good 

We rated it as **good**.

## Service delivery to meet the needs of local people

- The service planned and provided services in a way that met the needs of the local NHS trusts, private providers, other external stakeholders, and the research conducted in collaboration with the medical school. The provider held a mix of NHS and private contracts.
- This was evidenced in acquisition of new contracts, an active recruitment drive and the planned changes to extending the opening hours to meet local demand.

## Meeting people's individual needs

- The service took account of patients' individual needs.
- A detailed assessment of the patients' needs was made prior to the procedure. All referrals were reviewed twice, once upon receipt and again the day before the procedure to ensure the service could meet the needs of patients.
- If specific needs were identified, they were communicated to service staff to ensure appropriate planning before the scan. If the referral was for an inpatient from the local NHS trust, contact was made with the clinical area to make sure the following areas were discussed: the condition of the patient, existing medical history, availability of nurse escort, translation requirements, transport arrangements. If translation services were required, they were booked and provided at the point of referral. Data showed 46% of patients were offered a scan appointment by the referring organisation within four to seven days of the referrer identifying the need for a scan. A further 40% received an appointment within eight to fourteen days, and the remaining cohort (15%) waited 15 days plus.
- Patients were provided with verbal and written procedure-specific information to help them make informed choices about their care and treatment. The patient survey indicated high levels of satisfaction with the information provided pre-procedure. Staff provided patients with more detailed information as part of the consent process.
- Staff told us that patients with a learning disability or mental health condition were identified prior to the procedure. This allowed staff to assess the individual care needs of this patient group before their appointment.

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- Staff provided detailed explanations of the procedures prior at the consent stage. This provided an additional opportunity for patients to raise a concern or ask questions.
- Scrubs (cotton, short-sleeved shirt and drawstring trousers) were provided to patients which promoted patient dignity and avoided the need for open backed gowns.
- Patients was given information regarding the next steps in their pathway, i.e. the scans were sent with electronically with immediate effect to be reported. This was given verbally alongside written information including who to contact in the event of any side effects.
- If there were any immediate life threatening findings that required immediate action, staff raised their concerns via telephone with the dedicated contact at the nuclear medicine team at the local trust.
- The service monitored missed appointments. In the first instance, staff called patients who did not attend. They also contacted the referrer to make them aware of any missed appointments.
- The service was located on the local university campus. There was a set protocol which indicated a set meeting place for ambulances in the event of an emergency. A staff member met the ambulance and guided them to the centre. This was in place to ensure there was no uncertainty or delays in the response to an emergency. There was an allocated ambulance parking and turning bay, which was marked 'keep clear' at all times.
- The service had several reserved parking spaces for disabled badge holders which were next to the building. All other attendees were provided with reduced price parking vouchers. The receptionist proactively ensured patients were parked in an appropriate space, and offered a parking voucher when they presented to reception.
- Appointments were made according to urgency specified in the referral. This meant patients requiring urgent procedures had access to the service.
- The service had contractual key performance indicators (KPIs) agreed with the local NHS trust and other independent health providers. The service was compliance with all access and flow Key Performance Indicators. Appointment cancellations were rare. Performance was continuously monitored to make sure the service was meeting these requirements.
- Appointment times were tailored to meet the needs of individual patients. For example: diabetic patients taking insulin were scheduled for later in the day. Non-insulin dependent diabetic patients were scheduled earlier to ensure minimal disruption to medication regimes. Memory assessment patients tended to be scheduled for later in the day as the service showed this suited this type of patient best as highlighted by recent research.
- Between July 2017 and June 2018, the service reported cancelling 201 scans. The most frequent reasons for cancelled procedures related to the timely availability of radioactive tracers. Radioactive tracers are used to assess bodily functions and to diagnose and treat disease. This appeared to be a regional concern and not isolated to this provider. At the time of the inspection this had been resolved by the senior leadership team.

## Learning from complaints and concerns

- The service treated concerns and complaints seriously, it investigated them, learned lessons and used the learning to improve the service.
- We saw a complaints policy which reflected best practice. It was easily accessible to staff. The provider had systems to ensure patients comments and complaints were listened to and acted upon effectively. Patients could raise a concern and have it investigated and responded to within a realistic time frame.
- Comments and complaints were used by the management team to improve the quality of the service provided.
- Patients who had concerns about any aspect of the service received were encouraged to contact the centre in order that these could be addressed. These issues were managed through the complaints procedure. The service lead was responsible for the management of complaints.

## Access and flow

- People could access the service when they needed it. Despite the high demand on the service, there was retained capacity to facilitate urgent scan requests.
- The service updated the referring organisations of the availability of scanning slots approximately four weeks in advance. Referrers determined the priority of individual patients for scanning based on clinical priority, pathway requirements e.g. cancer and waiting times.

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- The service received three complaints within the inspection time frame. The service had two named individuals who had responsibility to respond and investigate to any concerns made. All three complaints were successfully resolved within the recommended time frame.
- Staff gave inspectors examples of changes to practice from concerns and complaint investigations. For example we saw some comments from patients expressing dissatisfaction with parking and signage which the service had addressed which evidence the service used feedback to improve the service.
- This meant that complaints were discussed with staff and resulted in changes in practice. For example, we saw some comments from patients relating to parking and signage.
- No complaints had been referred to the ombudsman or the Independent Healthcare Sector Complaints Adjudication Service (ISCAS), an independent adjudicator.

## Are diagnostic imaging services well-led?

Good 

We rated it as **good**.

### Leadership

- The service had managers with the right skills and abilities to lead the service. There was a well-defined leadership structure with clear lines of accountability. The service was managed by the Head of Radiography, Academic Director, Clinical Lead or the Business Director. Staff knew how to access leadership support and felt able to raise concerns or make comments freely.
- The manager was committed, passionate about patient care, and delivering a high-quality service. They were also committed to the staff team whom they worked alongside. The manager told us “I have a good team behind me, I feel supported by them”.
- Staff told us the leadership team were visible and approachable. They told us they felt very supported by their line manager and felt proud to work in the service.
- The managers told us they had recently been through a challenging time whilst re-negotiating contracts. The senior team were privy to sensitive information that they were unable to discuss with staff. The leadership team

were aware of the anxiety to staff so they tried to provide as much assurance and support as possible and offered to contact the union on the staff behalf when the terms and conditions of their work contracts were re-negotiated.

### Vision and strategy

- There was a suitable vision and strategy for the service. The service aimed to provide high quality diagnostic imaging, conduct world class research, educational and clinical development opportunities.
- Staff felt involved in its development and committed to its delivery. This was evidenced in the meetings held with staff prior to the acquisition of a new contract. There was active recruitment for additional staff, as well as introducing the extended opening hours which reflected the changing service vision and strategy.

### Culture

- From our interactions and observation of staff during the inspection, we found the team to be cohesive, dynamic and open. We saw the team communicate well with each other and with patients. We saw a positive attitude towards work and saw the team effortlessly support each other throughout the day.
- The service manager told us the service promoted an open and blameless culture. Staff also told us they felt they had an open and honest approach to working in the service.
- All independent healthcare organisations with NHS contracts worth £200,000 or more are contractually obliged to take part in the Workforce Race Equality Standard (WRES). Providers must collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality. At the time of inspection, the service had not undertaken a WRES audit.
- All independent healthcare organisations with NHS contracts worth £200,000 or more are contractually obliged to provide staff with access to a Speak up Guardian. The development of the Freedom to Speak Up Guardian role was a recommendation made by Sir Robert Francis in “Freedom to Speak Up” in 2015. At the time of the inspection there was no process for staff to access a speak up guardian and the leadership team were not aware of this requirement.

### Governance



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- The service had a governance framework which was used to monitor the quality of the service provided.
- The governance structure consisted of a Clinical Executive Group (CEG), which reported to the Clinical Management Group (CMG), which reported upwards to the service Strategy Board. The Clinical Imaging Science Centre Strategy Board was established by both universities, and reports to the Joint Board (JB) of the two Universities quarterly.
- There were two governance leads for the service which included an academic director responsible for corporate governance, and a consultant clinical lead from the local NHS trust.
- There was a Clinical Executive Group (CEG) which was led by the clinical lead of the centre. This group was responsible for providing assurance and oversight in the following areas: strategy and policy for clinical imaging services, clinical governance, clinical standards, clinical protocols, safety of human subjects, patients and accompanying persons, interface between the local trust and other clinical partners on matter of clinical service provisions and clinical training.
- Clinical Executive Group meetings were held every quarter and had a standardised agenda, and was in-line with the agreed terms of reference. There was a standardised approach to these meetings and the minutes we looked at showed actions were reviewed appropriately and in a timely manner.
- Performance data was routinely collected and collated to make sure the service was meeting the key performance indicators outlined in service contracts. This data was presented and challenged at the governance meetings.
- Feedback from these meetings were provided to staff via the service manager. Staff felt the governance process worked well in the organisation.

## Managing risks, issues and performance

- The service had effective processes to identify, understand, monitor and address current and future risks.
- A formal risk register was held and reviewed regularly. The recorded risks were Red, Amber, Green, (RAG) rated. A 'RAG' rating is a common traffic light rating system which colour codes the risks according to the entries according to the level of risk identified.
- The service used a risk register to monitor and mitigate risks. Service risks were reviewed quarterly by the

Clinical Executive Group and fed into the university risk register. The service risk register we looked at had a total of 21 risks which were all rated as low or moderate. The register we viewed demonstrated risks were being recorded, reviewed and had mitigations in place. The leadership demonstrated a clear understanding of the risks in the service and could tell inspectors what steps were taken to lessen these risks. However, we noted the risk register did not contain an entry about the potential risk to the service relating to the non-availability of radioactive tracers which previously resulted in list cancellations.

- The service had a radiation protection committee. The role of the committee was to have oversight of all matters relating to the safe transport, use, storage and disposal of materials producing ionising radiation and the use of all equipment. It also had a function to oversee compliance with relevant statutory provisions and approved codes of practice. We saw meeting minutes which showed the committee met quarterly to discuss, and manage any identified risk, areas of concern, or service development opportunities.
- The service had a disaster recovery plan which contained a suitable approach to dealing with an unforeseen event.
- We also saw a managing risk and decision making policy that aimed to guide staff through the centre risk management processes.

## Managing information

- The centre collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service had contacts with three local NHS trusts and three independent health provider. Each had their own arrangements for electronic image transfer. The provider ensured that staff were able to transfer images to the relevant referrer in a timely way.
- Arrangements were in place with each organisation to provide staff with training and IT support should the team need it. We saw each system ran on its own computer. Staff felt, given the need for three different systems, the current provision worked well.
- The majority of records was electronic. Occasionally additional paper records were created during a patient visit. These were scanned to the electronic system and became part of the electronic record. Paper records were then destroyed in line with best practice guidance.

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- All staff (100%) had completed data protection training as part of their mandatory training. This meant the service was compliant with the commercial third parties information governance toolkit published by the Department of Health which says, all staff should have training on information governance requirements.

## Engagement

- Care was provided by a small and well-integrated team. This meant, staff engagement happened daily and was not formalised, other than in staff meetings.
- Staff told us they felt engaged with the leadership and the service and did not raise any concerns with inspectors. Staff had access to occupational health and wellbeing initiatives offered by the university.
- The service proactively sought the views of service users and use this to improve their experience of using the centre.

- The service routinely invited research nurses and coordinators from the Clinical Trials Research Unit to come and see what is involved in PETCT and MRI. This is to ensure they were better informed when recruiting to clinical trials. The feedback was very positive and subsequently led to other staff from the research unit requesting to experience the service.

## Learning, continuous improvement and innovation

- The service used information from incidents, complaints and the patient satisfaction survey to drive continuously improvement. It also used market forces and research opportunities to drive the vision and strategy.
- The service supported many university research projects including MRI techniques, neuroscience, psychiatry and consciousness.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider **SHOULD** take to improve

The provider should develop a safeguarding children policy that reflects best practice outlined in the Royal Colleges intercollegiate document.

The provider should review the infection, prevention and control policy and update it to ensure quality control measures are included. This should include the frequency of environmental, equipment and hand hygiene, quality assurance processes.

The provider should provide all staff with ongoing Mental Capacity Act training.



This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

This section is primarily information for the provider

## Enforcement actions

### Action we have told the provider to take

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