

Alliance Medical Limited

Sidcup PET-CT Centre

Inspection report

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Date of inspection visit: 20 April 2022
Date of publication: 10/06/2022

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location

Good



Are services safe?

Good



Are services effective?

Inspected but not rated



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

Overall summary

This was the first time we rated the service. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse. The service controlled infection risk well. Staff reviewed referrals to identify risks to patients and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available to provide care within defined time scales.
- Staff treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Not all staff were sure who to call if a patient was rapidly deteriorating.
- Patient's told us they found the leaflet about parking confusing.
- Not all folders were updated with policies when they were printed.
- The service was recruiting more staff but while this was being processed the service manager was having to work clinically and so relied upon support from other managers.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	

Summary of findings

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Summary of this inspection

Background to Sidcup PET-CT Centre

Sidcup PET-CT centre is operated by Alliance Medical Limited. Sidcup PET-CT provides PET-CT imaging within the grounds of an NHS Trust. They provide imaging services for NHS trusts and are contracted by NHS commissioners to do so. The service also accepts private referrals.

The service provides a diagnostic imaging service for patients who require a PET CT scan. A PET-CT scan is a combination of a PET (positron emission tomography) scan and a CT (computerised tomography) scan. The PET scan shows how active cells are in different parts of the body using a radioisotope injection. The CT scan takes a series of pictures using x-rays to build this information in to 3D pictures of the body.

The service had been registered since 2020 and had a registered manager in place. There was an application in for the new service manager to take over the registered manager role. We had not previously inspected this service.

How we carried out this inspection

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.

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a service **SHOULD** take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take action to improve:

- The service should ensure that all staff are clear about emergency protocols and who to call in the event of a rapidly deteriorating patient.
- The service should continue to recruit into vacant roles to allow all members of staff to fulfil their roles in full and not rely upon support from others.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Inspected but not rated	Good	Good	Good	Good
Overall	Good	Inspected but not rated	Good	Good	Good	Good

Diagnostic imaging

Safe	Good 
Effective	Inspected but not rated 
Caring	Good 
Responsive	Good 
Well-led	Good 

Are Diagnostic imaging safe?

Good 

Mandatory training

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

Staff received and kept up-to-date with their mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff ahead of when they needed to update their training.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse using the safeguarding referral process.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Cleanliness, infection control and hygiene

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.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained and the service performed well for cleanliness in their audits

Diagnostic imaging

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). All clinical staff were bare below the elbow and washed their hands regularly.

The service was still following policies to reduce the risk of staff and patients contracting COVID-19.

Staff cleaned equipment and rooms after patient contact and labelled equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

Patients waiting in individual patient rooms could reach call bells and staff responded quickly when called. The call bells were checked once a week to ensure they were still working.

The design of the environment followed national guidance.

There was a designated “hot toilet” and “cold toilet” meaning patients who had been injected with the radioisotope used a separate toilet after injection. A “hot toilet” is a toilet specifically for use by patients following injection with radioisotopes, this is because following injection urine contains low levels of radiation.

The individual patient rooms and scanning room all had live CCTV in to allow staff to monitor patients, without having to be in the room with them and expose themselves to radiation. There were signs in every room letting patients know they were being observed on CCTV.

The department was secure and had warning signs wherever any radioactive substances might be. Rooms used to store radioactive substances were secured with keypad access.

Staff carried out daily safety checks of specialist equipment in line with manufacturers guidelines. All specialist equipment was also regularly serviced by the manufacturer.

The service used a machine to calculate and draw up the amount of radioactivity needed for each patient. This supported staff to remain safe, as it reduced the radiation dose they received and the risk of spilling radioactive substances and any wastage.

The service had enough suitable equipment to help them safely care for patients. The emergency trolley was checked daily and had up to date resuscitation council guidelines and algorithms readily available.

Staff disposed of clinical waste safely. The service had multiple contracts for waste disposal and segregated waste as per guidelines.

Assessing and responding to patient risk

Staff reviewed referrals and ensured they had all the information required for each patient. Staff were trained to identify and act upon patients at risk of deterioration, but not all staff were clear about the steps to take to call for help.

Diagnostic imaging

Staff were not all clear on who to call for support if a patient suddenly deteriorated. All staff who had contact with patients were trained to an intermediate life support level so could competently start life support. However, they were unclear about who to call to get ongoing support and care for the patient. Staff were able to quickly locate the policy and tell us who they would call.

Staff reviewed referral forms prior to booking patient appointments to ensure scans were justified and that they had all the information needed to perform a scan.

When booking an appointment staff asked patients if they were diabetic or claustrophobic. This meant they could tailor their advice about fasting, for diabetic patients or could provide longer appointment times for claustrophobic patients to ensure they had time to feel calm.

Staff were all clear about how to ensure any urgent scans were flagged to reporting teams quickly to ensure the turnaround times were minimised and reports were written quickly.

Staff carried out a series of checks with patients before undertaking scans including relevant medical history, history of scans, pregnancy status and allergy checks. Staff explained the risks associated with the scan and the safety precautions required after the scan.

Staffing

The service had just 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 had enough radiographers, nuclear medicine technicians and support staff to keep patients safe. However, the service acknowledged they were very tight with staffing numbers and had to reduce their capacity if a member of staff called in sick or was on annual leave. They were recruiting more members of staff and had a new member of the team starting soon.

Managers reviewed the number of staff needed for each shift and were able to adjust patient numbers accordingly, to ensure there was a safe day planned. Due to the radiation dose staff received they were only able to scan 10 patients per day. If the service knew a member of staff was going to be off rather than use bank or agency staff, they reached out to other scanners in the local area for support, that were run by the same parent company. This was planned into the overall staffing establishment numbers for the area to ensure all services could run safely.

As the team was small turnover rates looked high, however only one member of staff had left recently and a new member of staff had been employed and was going through pre-employment checks.

The service's sickness rates appeared high, but this was because a member of staff was away for a long period of time and the service was small.

Medical staffing

The service did not directly employ any medical staff. Any support required from clinicians was contractually arranged, or was provided by the wider parent company's systems and processes.

Diagnostic imaging

All PET-CT services must have a doctor who is clinically responsible for all the scans and who decides and approves the criteria for all referrals. This person holds a license to do so under the Administration of Radioactive Substance Advisory Committee (ARSAC) and is known as an ARSAC license holder. The service had a contract to provide this service from a clinician who they did not directly employ. There were clear policies and protocols describing how this arrangement worked and what was expected of the clinician.

The service had access to a pool of reporting clinicians, who were employed by the parent company. If a scan needed reporting urgently there were reporting co-ordinators the staff could contact to arrange this.

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.

Patient notes were comprehensive and all staff could access them easily. Records were split into sections to make them easy to navigate and every interaction with patients was added, including booking calls.

As much information as possible was created and stored securely in electronic patient records, that were accessible to all staff with the rights to see patient records. This meant almost as soon as scans were completed reporters were able to review them and to report on them.

When patients transferred to a new team, there were no delays in staff accessing their records. The service had its own secure image sharing portal to share images with the reporting team. They also had access to NHS imaging portals to share images and reports with the hospital's patients were referred from.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. The primary medicine the service had on site was the radioisotope they used for the PET-CT scans. Radioisotopes were justified for use by the ARSAC license holder, or their delegate, as defined by policies.

The dose of radioisotope to be given was calculated by an automatic drawing up machine that had the radioactivity level input and the patients weight input to calculate an accurate dose. This machine improved the accuracy of drawing up and reduced the radiation dose staff received each time they drew up the radioisotope. The machine also reduced the likelihood staff might accidentally spill anything.

The radioisotope was delivered from two radiopharmacies three times throughout the day. This was required as the radioactivity reduced rapidly, so to achieve good quality scans multiple deliveries were required. A radiopharmacy is a pharmacy that has specialist equipment to create the radioactivity required.

The service had the equipment to safely store and dispense the dye used for CT scans. At the time of the inspection the service did not have a contract to provide this service, so the dye was stored away securely.

The service had emergency medicines in the emergency trolley. These were secured and checked with the other emergency equipment.

Diagnostic imaging

Incidents

The service managed patient safety incidents. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the team. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents, including serious incidents, to report and how to report them in line with the service's policy.

The service had no never events.

Managers shared learning with their staff about incidents that happened elsewhere. The service manager joined a meeting every week to share learning from incidents with all other service managers from the parent company.

Staff understood the duty of candour. They were open and transparent, and knew they needed to give patients and families a full explanation if and when things went wrong.

Are Diagnostic imaging effective?

Inspected but not rated 

We do not rate effective for diagnostic imaging services.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

The service's policies and procedures were reviewed annually by the radiation protection advisor (RPA). The most recent RPA audit was in November 2021 and found that there were two minor changes required. We were provided evidence these had been acted upon since the audit.

To ensure only safe radiation doses were received by patients the service use the Public Health England (PHE) guidance on national dose reference levels when reviewing their local dose reference levels for PET-CT imaging. National dose reference levels are a national average dose that services should aim to not exceed unless there is justification for exceeding it. Services should aim to compile local dose reference levels for their specific equipment. The service audited their compliance with their local dose reference levels and achieved 100% compliance at the most recent audit.

The service had compiled local data for CT scans and this was with being used by their medical physics support to determine accurate local dose reference levels for CT scans. While this was being calculated the service worked to the published national dose reference levels.

Staff exposures were regularly monitored. Staff wore dose monitors on clips on their uniforms and also dose rings to measure their finger dose.

The service had clear local rules for every area, including individual patient rooms.

Diagnostic imaging

Nutrition and hydration

Staff made sure patients did not fast for too long before diagnostic procedures.

Due to the nature of the service provision food and drink was not necessary. However, there was water and tea in the waiting room for patients, once their scan was completed, if they wanted.

Staff offered diabetic patients scans early in the morning to help them manage their blood sugars. They also gave different fasting advice, to safely balance the need to fast with the patient's other health needs.

Pain relief

Staff asked patients if they were in pain.

Staff advised patients to take any prescribed pain medicine before they attended the centre.

Staff ensured patients were as comfortable as possible while on the scanner. The scanner was a new digital scanner, this meant scans were fast and patients did not have to lie still for too long.

Patient outcomes

Staff monitored the effectiveness of care and used the findings to make improvements.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There was an audit calendar, which was monitored by the service manager. All local audit results we saw were positive and showed the service consistently performed to a high standard.

Local audits included reviewing the timeliness of scans being booked and reported, reviewing that all applicable patients were asked if they could be pregnant and recording of consent being confirmed.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time.

Managers shared and made sure staff understood information from the audits. Audit results, and action plans, were discussed at the monthly team meetings to ensure staff were aware of any necessary changes.

The service held Health and Safety Executive (HSE) registration for ionising radiation, including for nuclear premises. The parent company was accredited by the United Kingdom Accreditation Service (UKAS) for the quality standard for imaging.

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 were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All health care staff were registered with the professional bodies and maintained their registration. Only registered staff were permitted to inject patients with the radioisotope.

Clinical assistants were not registered with a professional body, they worked under a clear scope of practice and understood what they could and could not support the team with.

Diagnostic imaging

Managers gave all new staff a full induction tailored to their role before they started work. The service hired staff to work as both administrators and clinical assistants, to allow for flexibility in the workforce. These staff members received appropriate training and support for each role.

Managers supported staff to develop through regular, constructive appraisals of their work.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge including specialist training.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients.

Staff worked together with the hospitals that referred patients into them to ensure they had all the necessary information to scan a patient before they arrived in the department.

Seven-day services

Key services were available to support timely patient care.

The service worked four days a week and scans were booked in according to priorities. The service had to limit their opening hours due to staffing levels. If scans were required on days the service was not open they offered patients the option to attend a different department nearby.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff had received training and understood how and when to assess whether a patient had the capacity to make decisions about their care. Patients attending the centre for a scan were pre-assessed for mental capacity by the referring doctor.

Staff gained consent from patients for their care and treatment in line with legislation and guidance and all the information available. Patients were consented for scans verbally but were also given leaflets and written information in their booking letter to further explain the scanning process.

Staff clearly recorded consent in the patients' records.

Are Diagnostic imaging caring?

Compassionate care

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

Diagnostic imaging

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. All patients we spoke with told us staff were friendly and had time to answer any questions they may have.

Administrative staff checked if a patient was claustrophobic before they booked them a scanning slot. If a patient were claustrophobic they could book time before their appointment to show them the scanner and see if they would be able to manage the scan. This meant claustrophobic patients did not feel pressurised into having the scan if they felt unable to continue.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. In the waiting room there were signs explaining that the service only had female staff working, and if a patient preferred a male member of staff to do their scan they could ask to be scanned at another centre. The chaperone policy was displayed in the waiting room

Emotional support

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

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing. Staff we spoke with were clear about the importance of talking to patients as individuals and made sure they took patients to the individual patient rooms before having any conversations about their care.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff were able to support patients who became distressed in an open environment, and could help them maintain their privacy and dignity.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand the process and make decisions about their care.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary and made sure patients and those close to them understood their care. All information patients were given verbally was also duplicated in leaflets which had both words and pictures to depict what to expect.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Feedback was overwhelmingly positive about the care patients received and how clear the staff had been about the process.

Staff supported patients to make informed decisions about their care.

Diagnostic imaging

Most patients were encouraged to sit alone once the radioisotope had been injected. This was because anybody sitting close to the patient would receive a radiation dose. However, patients who were distressed or needed extra care were able to have a carer with them. Staff explained the risks to carers and provided them with a dosimeter, so they knew what radiation dose they received. Carers were asked to sign a document to confirm they understood the information they were told.

Due to the service's reliance on radiopharmacies and regular deliveries being available patients were informed that there was a chance their scan might be cancelled, due to a production or delivery failure.

The environment was designed to be pleasant and relaxing for patients while they had to wait for an hour in individual patient rooms after being injected with the radionuclide.

Patients who paid for their scans privately were informed of all costs before the scan was carried out. The administrative staff explained to patients with private health insurance how to get codes from insurers to ensure they would not have to pay.

Are Diagnostic imaging responsive?

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.

Managers planned and organised services so they met the changing needs of the local population to allow them to meet the needs of their contract with NHS England. This included achieving referral to booking timescales defined by NHS England.

Facilities and premises were appropriate for the services being delivered. There were six individual patient rooms, one of these rooms had a clinical couch in. This meant if a patient was unable to sit upright they had space to lie down. Corridors were wide enough to use wheelchairs or patient trolleys in if a patient required this.

Managers monitored, took action to minimise missed appointments and contacted patients who missed appointments.

The service supported other PET-CT scanners run by the same provider when required to minimise disruption to patients. The service manager explained that if another close by service had a machine breakdown patients would be offered scans at this service, and vice versa.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. There had recently been extra training about meeting the needs of patients who were unable to verbalise themselves.

Diagnostic imaging

Clinical staff completed training on recognising and responding to patients with mental health needs and dementia.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Staff spoke with patients ahead of their scan to identify anybody who might need extra support or a longer period of time in the scanning room.

The service was completely step free and patient toilets were accessible for patients with mobility limitations.

Patients were all given a basket on wheels to keep their personal belongings in while they were in the centre.

There was an equality and diversity policy to guide staff to access the right support for patients with additional needs.

The centre had six individual patient rooms, where patients sat to have the radioisotope injected and wait for an hour for it to be absorbed into their system. These rooms provided private space for patients to ask questions and raise any concerns they might have.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times for treatment were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within contracted time frames. In the three months prior to inspection the service met their contracted targets most of the time, they often exceeded the seven day turn around time target. We were told the few times they did not achieve their targets was due to patient choice and not wanting to have their scan at the time.

Managers worked to keep the number of cancelled appointments to a minimum. There were times the service had to cancel scans, the most common reason was because the radiopharmacy was unable to deliver the radioisotope, or the radioisotopes had failed quality checks. Patients were prepared before attending that this might happen, this was outside of the service's control and happened infrequently.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns the complaints process was visible for them.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Diagnostic imaging

Are Diagnostic imaging well-led?

Good 

Leadership

The service manager had the skills and abilities to run the service, but lacked the time to complete their role due to conflicting priorities. They understood the priorities and issues the service faced, but lacked the time to manage them and relied upon support from other managers. 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.

At the time of the inspection the service manager was having to support with clinical duties, until a new member of the clinical team started. This limited their capacity to carry out their management duties. During this time managers at the parent company, and from other nearby locations were supporting them to run the service safely.

The service manager regularly worked alongside their team, as they were supporting clinical activities. The team told us they felt comfortable to ask questions if they needed to. The service manager told us they felt supported by other local managers and managers at the parent company.

Just before inspection there had been internal recruitment to the more senior roles and these staff were now being offered training courses to support them in their new roles.

Vision and Strategy

The service had a vision for what it wanted to achieve but we were not shown a formal strategy to turn it into action. The vision was focused on increasing the scanning capacity and therefore were aligned to local plans within the wider health economy.

We were told the service was working towards increasing their scanning capacity to allow a greater number of patients to be seen each day. This would allow them to increase their contracts with NHS commissioners and would help to improve the diagnostic wait times within the wider NHS. However, at the time of inspection the scanning capacity was limited by the number of clinical staff it currently had.

We requested the written formalised vision and strategy but were not provided this for some time. So, although one was written we were not able to be sure this was being referred to regularly by the team to guide or measure their success.

Culture

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

Staff told us they enjoyed working for the service and felt supported and valued and were able to always ask questions or raise concerns.

Team members who were new into role, or new into the service all told us they were being supported into their new roles. Members of the team who had been in their role for longer told us they were still being offered training to support their development and did not feel that their development was being ignored.

Diagnostic imaging

The service carried out a regular staff survey, the results from the staff survey supported what members of the team we spoke with told us. This survey included questions about equality and diversity.

The service considered the impact of changes to policies on equality and diversity. Policies we reviewed all had equality impact assessments completed. This ensured they had considered the needs of staff and patients and reflected upon the potential effects the policy may have on people with protected characteristics.

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.

There were clear channels of communication between staff and with other services within the parent company. Staff were aware of their responsibilities and, where operational pressures were prohibiting the service manager completing their full role, they were able to access support to ensure their responsibilities were completed and there was oversight of the service.

Medical physics support was provided by a nearby NHS trust under a contractual arrangement. Staff were clear about how to contact the medical physics team if they required support or had a query.

The wider parent company had governance and risk leads that the service fed information into oversight meetings at the parent company for discussion and review, the service manager attended these meetings.

There was a radiation protection committee that the service participated in, to review adherence to policies and procedures. We reviewed minutes from this meeting and could see that the service was discussed and participated in discussions.

The service ran monthly team meetings where audit results, performance and risks were discussed.

The wider parent company sent a weekly newsletter email to all service managers reminding them of topics to be highlighted and discussed at daily huddles. This included things such as upcoming updates, reminders to complete audits and training courses.

Management of risk, issues and performance

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

There were weekly meetings with all service managers who worked for the parent company to discuss incidents, to ensure learning was shared and to reduce the likelihood of incidents being repeated elsewhere.

The service had a local risk register, which was reviewed regularly. At the time of the inspection the service manager was being supported to review the risk register, due to the impact of their clinical responsibilities on their capacity.

The service was mostly meeting their contractual scanning turnaround time targets. Where targets had not been met there were clearly documented reasons for scans being delayed.

Diagnostic imaging

There were identified mechanisms for sharing external alerts, such as medicines alerts, to ensure safety could be maintained for patients.

The service did not have back up emergency generators, we were told this was because the power supplied from them would not be enough to power the scanner. However, the service did have an emergency power supply to ensure the scanner could be shut down in a safe manner, in the event of a power outage.

We saw notes of discussions where incidents had been discussed with medical physicists about the potential need to report them to external bodies. The review we saw did not meet the threshold for external reporting, but the mechanisms were in place if this was required.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats. The information systems were integrated and secure. Data or notifications were consistently discussed and considered for submission to external organisations as required.

The service worked almost exclusively with electronic records that were password protected. We observed all staff followed good information governance procedures and logged out of any computers they were not using at the time.

Staff explained how referrals, scans and reports were securely shared with teams that worked externally to the service.

The use of electronic records meant information was all time stamped and could not be amended, without a comment explaining why. Therefore, the service was confident they were using accurate data for audits and reviews.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

There were monthly team meetings where staff were encouraged to raise ideas or concerns. Staff told us they felt confident to question changes and were able to speak out if they felt something might be unsafe.

Patients' views and experiences were gathered and acted upon to shape the service. The service asked for feedback following each scan and used this to plan the future of the service.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods. Leaders encouraged innovation and participation in research.

The parent company was in the process of setting up patient engagement forums to gather further views from patients about the service. The patient engagement forums had been trialled and were proposed to become a regular meeting which we were told would commence shortly.

The service supported research trials, and had a lead who coordinated the scans and ensured they followed trial protocols.

Staff at all levels told us they were offered training to support their development.