Ashford PET- CT Centre

Quality Report

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Website: www.alliancemedical.co.uk/scan-centres/ashford-pet-ct-centre

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

Ratings

Overall rating for this location	Good
Are services safe?	Requires improvement
Are services effective?	
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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.

Summary of findings

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

Services we rate

We rated it as **Good** overall.

We found good practice about diagnostic imaging:

- The service provided mandatory training, including radiation risks, safeguarding, as well as service specific competencies to all staff and made sure everybody completed it.
- Premises and equipment were suitable and well maintained.
- The service had enough staff with the right qualifications, skills, training and experience to provide the right care.
- Staff kept record of patients' care. Records completed by staff were clear and completed appropriately. Radioactive medicines were stored and administered in line with best practice.
- The service managed incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared the learning across the organisation.
- The service provided care and treatment based on national guidance. Managers checked to make sure staff followed the guidance.
- Staff worked together as a team to benefit patients.
- Staff understood their role and responsibility under the Mental Capacity Act (2005).
- Staff cared for patients with compassion. Patients' feedback showed staff treated them with respect and kindness. Staff put patients at ease and explained procedures in a way that patients and those close to them understood.
- The service took account of patients' individual needs.
- The service treated complaints and concerns seriously. Lessons learned were shared across the organisation.
- Managers had the right skills and abilities to run a service providing high quality care. They promoted a positive culture that valued staff.
- The organisation had governance systems in place.

However, we found areas of practice that require improvement:

- Staff were unclear on what constituted a safeguarding concern and how to report a safeguarding issue.
- Staff did not always decontaminate equipment in between patient use.
- Staff did not always follow the five moments of hand hygiene and did not clean their hands before patient contact.
- There was no information or leaflets available in formats such as easy to read or in languages other than English.

Nigel Acheson

Deputy Chief Inspector of Hospitals

Overall summary

Summary of findings

Ashford PET-CT Centre is operated by Alliance Medical Limited. Alliance Medical Limited provides PET-CT Scan Imaging within the grounds of an NHS Trust in the South East of England, through a national contract commissioned by NHS England. The service has previously been delivered using a mobile unit. In August 2015 a static unit was built within the hospital grounds and opened on 15 March 2018.

The service provides a diagnostic imaging service for patients who require a PET CT scan. A PET-CT scan is a combination of aPET (positron emission tomography) scanand aCT (computerised tomography) scan. The PET scan shows how active cells are in different parts of the body using a radioactive injection. The CT scan takes a series of pictures (x-rays) to build this information into 3D pictures of the inside of body. Local governance was monitored through regular meetings with the Administration of Radioactive Substances Advisory Committee (ARSAC) holder (a specialist licensed radiologist) in the NHS Trust. The service was also supported by the NHS Trust Medical Physics Team who provided a Radiation Protection Advisor, a Medical Physics Expert and Radioactive Waste Advisor.

We inspected this service using our comprehensive inspection methodology. We carried out a short notice announced inspection on 28 February 2019.

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

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	Ashford PET CT Diagnostic Imaging Centre provides positron emission tomography for NHS adult patients, privately insured patients and self-funding patients. The service provides scans for patients from across Kent. Since opening in March 2018 1,892 scans were carried out. We found that there was sufficient staff that were trained, skilled and competent to provide the service. The centre was visibly clean and the equipment was well maintained. Staff delivered care in line with best practice guidance. Patients were very positive about the experience of having a scan at the centre. Patients were treated as individuals and we observed patients being cared for with the utmost respect. Written information was available. However, it was not in a format other than English. An interpreting service was available. Managers supported staff in an open and friendly culture. Organisational governance and risk processes were in place with information shared with staff. Results of scans were with the referring consultant within two days of the scan being done.

Summary of findings

Contents

Good

Ashford PET-CT Centre

Services we looked at

Diagnostic imaging;

Summary of this inspection

Background to Ashford PET- CT Centre

Ashford PET-CT Diagnostic Imaging Centre is operated by Alliance Medical Limited. The service opened on 15 March 2018. Patients are referred primarily from NHS Trusts across Kent. The service also scans privately insured and self-funding patients.

The service has had a registered manager in post since 19 March 2018.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector and a specialist advisor with expertise in radiology. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

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.

Information about Ashford PET- CT Centre

The unit is registered to provide the following regulated activities:

- Diagnostic and screening procedures

During the inspection, we visited the scanning centre. We spoke with six members of staff including managers, consultant nuclear medicine physician, technologists, clinical assistants and administrators. We spoke with two patients and one relative. During our inspection, we reviewed four sets of patient records and two staff appraisal documents. Following the inspection, we reviewed three staff recruitment records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the services first inspection since registration with CQC, which found that the service was meeting all standards of quality and safety it was monitored against.

The service did 1,892 scans from 15 March 2018 to 28 February 2019. Most scans were for the NHS and a small proportion were for private patients.

The service employed a unit manager, radiographers, technologists, clinical assistants and administrators.

Track record on safety: no never events, no serious injuries, seven clinical incidents all low harm, 11 operational incidents all low harm, four radiation protection incidents, two moderate harm and two low harm.

There were no incidences of hospital acquired methicillin-resistant staphylococcus aureus (MRSA), hospital acquired methicillin-sensitive staphylococcus aureus (MSSA), hospital acquired Clostridium difficile (C.Diff) or hospital acquired E-Coli.

The service received one written complaint from March 2018 to February 2019.

Summary of this inspection

Services accredited by a national body:

- Imaging Services Accreditation Scheme accredited July 2018 and due for renewal July 2021
- ISO 27001 the international information security standard accredited June 2018 and due for renewal July 2021
- Investors in People accreditation accredited March 2018 and due for renewal in March 2020
- National Cancer Research Institute accredited May 2018 and due for renewal May 2019

Services provided at the centre under a service level agreement:

- Cleaning services (internal facility)
- Linen services
- Clinical and non-clinical waste management
- IT first response help desk
- Resuscitation services

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated it as **Requires improvement** because:

- Although staff had received safeguarding training they were unable to clearly describe a reportable safeguarding issue and the process they would follow to report it.
- Although the hand hygiene audit demonstrated compliance with the five moments of hand hygiene, during the inspection we did not observe any staff member cleaning their hands prior to patient contact.
- Staff did not always decontaminate patient positioning equipment in between patient use.

However

- The organisation provided mandatory training in key skills including radiation risks and ensured everyone completed it.
- The premises had suitable equipment and premises and looked after them well.
- The service had enough staff with the right qualifications, skills, training and experience to provide the right care.
- Staff kept records of the patients' care. Records were clear, fully completed and stored securely.
- The service managed patients' safety incidents well. Staff recognised incidents and reported them appropriately. Learning from incidents across the organisation were shared by the managers at the centre.

Are services effective?

We do not rate the effective domain in diagnostic services.

- The service provided care and treatment based on national guidance. Managers checked to make sure staff followed guidance.
- Staff monitored patients regularly to check if they were in pain.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held meetings with them to provide support.
- Staff worked together as a team to benefit patients.
- Staff understood their roles and responsibilities under Mental Health Act (2005).

Are services caring?

Good 

We rated it as **Good** because:

Summary of this inspection

- Staff cared for patients with compassion. Feedback from patients both verbally and via the organisational patient satisfaction survey was positive and confirmed staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise distress. We observed staff putting patients at ease while delivering care.
- Patients could bring relatives or friends to appointments for support. Staff involved patients and those close to them in decisions about their care.
- Staff explained planned procedures to patients in a clear way.

Are services responsive?

Good

- We rated it as **Good** because:
- The service delivered care as planned by the referring consultant.
- The service took account of patients' individual needs. There was a hearing loop present for patients who were hard of hearing and the whole centre was accessible for patients with reduced mobility.

However:

- Occasionally the radiological medicine was not able to be used for the scan due to a failure to meet the strict quality controls during manufacture. This resulted in the cancellation of patient scans.
- There was a lack of patient information leaflets in easy to read formats or in languages other than English.
- Information on how to complain was available for patients who needed it. The organisation shared lessons learned from complaints with staff to prevent recurrence.

Are services well-led?

Good

We rated it as **Good** because:

- Managers had the right skills and abilities to run a service providing high quality care.
- Managers promoted a positive and open culture that supported and valued staff.
- Governance processes were well established to monitor the service quality.
- The service managed and used information well to support its activities.
- The service involved patients and staff and worked with partner organisations effectively.

Summary of this inspection

- The service was committed to improving practice by learning when things went well or wrong.

Good

Diagnostic imaging

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

Are diagnostic imaging services safe?

Requires improvement

We rated it as **requires improvement.**

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Staff received training in areas relevant to their role, including radiation risks, health and safety, equality and diversity, information governance, moving and handling and resuscitation.
- Compliance targets for training was 90% apart from information governance which was 95%. Staff were reminded by email 60 days before they were due to date to book an update course. Records showed the centre met the 90% mandatory training target and achieved 94% in information governance.
- Mandatory training was delivered using a mixture of face to face training and online learning. Staff told us there were no obstacles to accessing the training.

Safeguarding

- **Not all staff understood how to protect patients from abuse.** Staff had training on how to recognise and report abuse.
- Although all staff had completed safeguarding training, most staff we spoke to could not describe what would constitute a safeguarding concern and could not describe the process for escalating a safeguarding concern.
- The service had a policy for reporting images that showed a potential non- accidental injury. Clinical reporting staff described what constituted a non-accidental injury and the process for escalating this concern.
- Organisational polices included a safeguarding adults and safeguarding children and young persons. The legislation working together to safeguard children was referenced. It also included female genital mutilation, child sexual exploitation and prevent. A flow chart of how to escalate a concern was included in the polices. Although safeguarding contact information was stored within the unit policy it was not displayed within the unit.
- Safeguarding leads were available locally and regionally for support for adults and children. This service did not treat patients under the age of 18 but children might accompany an adult being scanned. The organisation's child safeguarding lead, was trained to safeguarding level four, and reported to the medical director. Clinical staff were trained to level two and non-clinical to level one for adults and children. This met intercollegiate guidance 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff '(March 2014). Guidance states all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers should be trained to level two. All staff had been trained in safeguarding adults level one and two.
- There were no safeguarding incidents reported to the CQC between March 2018 and February 2019.
- Posters were displayed in the scanning room to prompt staff to follow the Society and College of

Radiographers 'Have you paused and checked'. We observed staff followed this six-point safety check list that ensured the right patient had the right radiological scan at the right time.

- Records showed that recruitment procedures were in place to protect patients from harm. For example, all staff had a disclosure and barring screen prior to employment.

Cleanliness, infection control and hygiene

- **The service almost always controlled infection risk well.** Staff kept equipment and the premises clean.
- There was no methicillin-resistant staphylococcus aureus, methicillin resistant aureus, clostridium difficile or Escherichia coli reported by the service from March 2018 to February 2019.
- Infection control was included in mandatory training for staff. From the annual infection and prevention control audit from August 2018 the centre scored 98% on the hand hygiene audit and 100% compliance for the insertion of peripheral vascular devices. On the day of inspection however, we did not see any staff washing or decontaminating their hands prior to patient contact.
- The waiting area, patient uptake room cubicles and examination areas were visibly clean and well organised.
- All staff we saw on the day of inspection adhered to the bare below the elbows policy in clinical areas.
- There was a daily cleaning schedule which had been completed. The service had a policy for precautions to be taken after patient with a communicable disease had been scanned. Staff described the deep cleaning of rooms which would take place in this scenario.
- Cleaning of the centre was completed by a housekeeper provided by the local trust. The centre's staff were responsible for cleaning the clinical equipment. Cleaning wipes were available in all rooms. However, during the inspection staff did not always decontaminate positioning equipment in between patients which increased the risk of cross infection.
- All privacy curtains included dates when last changed. The centre's policy was to change the curtains every 12 months or when soiled. Records showed the curtains had been in place since 5 March 2018.
- Sharps bins were present, including dedicated bins to collect radioactive waste. Six bins reviewed during inspection were correctly assembled, dated, secure and not over filled. Radioactive waste including sharps and linen were stored at the centre for three days before being disposed of via the trust's systems.
- Personal protective equipment such as disposable aprons and gloves were readily available. Wall mounted hand gel sanitisers were readily available in all areas. Posters describing the World Health Organisation (WHO) five moments of hand hygiene were displayed by every hand washing area. However, during our inspection no staff we observed washed or sanitised their hands before patient contact in line with the WHO five moments of hand hygiene.
- Legionella testing was carried out as per local policy. This was in line with the Health Technical Memorandum 04-01 (2006): The Control of Legionella, Hygiene, "Safe" Hot Water, Cold Water and Drinking Systems.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
- The service was in a purpose-built building located in the grounds of an NHS hospital and close to the main car park. The layout of the unit was compatible with health building note (HBN06) guidance. Health buildingnotes give best practiceguidanceon the design and planning of new healthcare buildingsand on the adaptation / extension of existing facilities.
- There was a service level agreement with the NHS hospital for a range of ancillary services including waste disposal and resuscitation.
- Staff and patients accessed the building used a main entrance which led into the waiting area which included an accessible toilet for public use. All other areas were restricted to staff access only. The area was security controlled with coded electronic doors. The code was known only to staff and was changed every six months or when a staff member left employment.

- Security controlled areas included a control room, three uptake rooms where patients waited for the radioactive medicine to be absorbed by the body before the scan. There was also a hot lab where radioactive medicines where stored and dispensed. A hot lab is where nuclear medicine technologists prepare the radioactive medicines needed to perform the scan.There was also a 'hot' toilet for patients who had received the radioactive medicine as the patients waste will be radioactive immediately after the scan. There was a dedicated area for resuscitation equipment and emergency spillage kit.
- Emergency resuscitation equipment included emergency drugs, a defibrillator, an oxygen cylinder and a suction machine. The contents of the trolley were secured with a tag, which was in place during the inspection. Records we viewed showed there were daily checks for items not tagged and weekly checks of the trolley and its contents. A spillage kit was available and staff knew how to use it.
- Records showed maintenance and clinical equipment quality assurance arrangements were in place to ensure that specialist equipment was serviced and maintained as needed. However, the centre had not been open a year so was yet to have annual maintenance checks.The centre was supported by medical physicists.
- Staff wore film badges to monitor radiation doses. The film badge is used to measure and record radiation exposure of the staff to endure it is within safe limits. These were processed by an external third party and the results reviewed by the centre manager monthly. Records showed if there was an increase in radiation dose recorded, it was reported as an incident and the centre led review in practice and skills training with the member of staff involved. For example, a member of staff had a high dose reading, this was reported using the electronic system. Records showed this was investigated by the management team and an action plan put in place to change clinical practice and prevent a reoccurrence.
- There was sufficient space around the scanner for staff to move and for scans to be carried out safely. Patients had access to an emergency call buzzer, ear plugs and defenders during scanning. A microphone allowed constant contact between the radiographer and the patient.
- Records showed each radiation room had a current risk assessment.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient.** They kept clear records and asked for support when necessary.
- We observed reception staff confirming the identity of the patient on arrival to the centre. We observed the patient had to declare their name, date of birth and address before administration of any radiopharmaceuticals and again prior to scanning. Pause and check posters were displayed for staff as a reminder to complete all checks including patient identification, correct date, dosages, no clinical reason not to proceed and secure management of scans.
- We saw risk assessments such as for the handling of hazardous substances safely, local rules for radiation safety and accidental dropping of a radiopharmaceutical.
- Patients were required to complete a data form that included demographic information, medical history, current medication, possible pregnancy for women aged from 18 to 55 years. The patients' height and weight were recorded to calculate the dose of radiopharmaceutical required.
- Patients were required to have an intravenous cannula inserted to administer the radiopharmaceutical. Blood was tested for glucose levels in line with best practice. Staff told us if the blood glucose levels were out of acceptable levels, the ARSAC holder was contacted to check if the scan should go ahead. High levels of glucose can affect the results of the scan.
- Staff could describe the process for escalating a deteriorating patient. There were service level agreements for resuscitation with the NHS trust. The centre manager/s told us trust staff had been trained in radioactive safety when resuscitating a patient who had received a radiopharmaceutical.

Good

Diagnostic imaging

- Records showed non-clinical staff had training in basic life support and clinical staff had training in immediate life support. The training was face to face and aligned to Resuscitation Council UK guidelines. The centre ensured there were always two immediate life support trained staff present on site when scanning patients. This was in line with the centre's resuscitation policy.
- Call bells were accessible in all patient uptake rooms. Following the administration of the radioactive medicine, the patient was required to wait for one hour for the medicine to absorbed by the body. Patients were advised to stay as still as possible to prevent absorption to the muscles.
- There were closed circuit cameras in all areas, with signs informing patients that this was for safety reasons. Staff could observe patients in the uptake room, during the waiting period. Patients could be viewed, during the waiting period, in the uptake rooms.
- Once in the examination rooms, signs and a hazard barrier indicated if the room was safe to enter. Patients were required to remove metal items such as spectacles and watches before scanning. Women were asked to remove bras; clothes containing metal zips were lowered while on the examination table.
- The radiation support supervisor was supported by a radiation protection supervisor as well as the reporting consultant nuclear medicine physician. The purpose of these roles is to minimise unintended, excessive or incorrect medical exposures, to ensure the benefits outweigh the risks of each exposure and to keep doses in diagnostics "as low as reasonably practicable" for their intended use
- The service had a policy for escalating unexpected results to the referring consultant. Reporting radiographers could describe this process and gave an example of when this needed to be done.

Staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- The centre followed the organisational policy 'Staffing Requirements in Support of a Safe Scanning Pathway'. Staff attendance rotas showed compliance with this policy. Any shortfall in staffing was covered by the neighbouring Maidstone PET CT Diagnostic Imaging Centre.
- All staff were required to complete an induction at the time of recruitment and had evidence of required mandatory training and competencies relevant to scanning procedures and equipment to follow a safe scanning pathway.
- There were no staff vacancies at the time of inspection. The centre did not use bank or agency staff.

Medical staffing

- A consultant nuclear medicine physician was in the centre and reported on scans two days a week. They were available to support the team by telephone when not on site. Staff told us they felt confident about calling the consultant nuclear medicine physician for advice at any time.

Records

- **Staff kept detailed records of patients' care and treatment.** Records were clear, up-to-date and stored securely.
- Referrals were received via a secure electronic system. The referrals were printed and checked for completion daily. The referrer of incomplete forms would be contacted to correctly complete the form prior to triaging the scan request. Printed records were kept securely within a locked cupboard on site and destroyed when scanning was complete.
- Staff completed the patient data form with the patient present and these were scanned onto a secure electronic system.
- We reviewed the records for four patients. These included referral forms and patient data forms and found them to be completed correctly. The records included the radiation dose the patient had received during the scan.

Medicines

- **Medicines were managed appropriately by the service.**

Good

Diagnostic imaging

- Radioactive medicines were administered under the authorisation of the Administration of Radioactive Substances Advisory Committee (ARSAC) license holder. Medicines management training was included in the mandatory training. Records we viewed during inspection were maintained for staff authorised to administer radiopharmaceuticals and showed that 90% of staff were compliant with this.
- Radioactive medicines were stored in the hot lab that had key-pad entry. The height and weight of the patient was programmed into the specialist machine. This calculated the amount of radiopharmaceutical needed for each individual patient. The medicine was dispensed in a sealed unit, administered to the patient and disposed of into a dedicated sharps bin.
- The only other medicines in the centre were the emergency drug boxes and intravenous fluids in the tagged resuscitation trolley.
- Medication and disposal of medication was provided by an external company on a contract.
- An organisational pharmacy advisor was available if needed. The pharmacist issued guidance and support at a corporate level and worked collaboratively with the clinical quality team on all issues related to medicines' management.
- There were no patient group directives in place in this service.

Incidents

- **The service managed patient safety incidents well.** Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff reported incidents via an electronic system. Staff told us they reported and received feedback about incidents.
- There had been no never events or serious incidents reported from March 2018 to February 2019. There had been no Ionising Radiation (Medical Exposure) Regulation incidents in the same time although there was a Medical Physics Expert available to seek advice in an event occurred.
- From March 2018 to February 2019 the centre reported seven clinical incidents which were all recorded as low harm, 11 operational incidents reported which were all low harm and four radiation protection incidents, two of which were moderate harm and two low harm. Records showed each incident was investigated and the learning or actions shared with the wider team during team meetings. None of the radiation incident required reporting to the CQC.
- In the event of a serious incident the service would investigate using a root cause analysis and the manager had received training in this. Learning was shared across the organisation using newsletters and minutes of meetings.
- Staff we spoke to could describe duty of candour. The duty of candour is a statutory (legal) duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. No duty of candour was required with the incidents that occurred since the centre opening.

Are diagnostic imaging services effective?

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness.** Managers checked to make sure staff followed guidance.
- The service adhered to best practice guidance including Administration of Radioactive Substances Advisory Committee and Ionising Radiation (Medical Exposure) Regulations.
- Policies and procedures were followed at provider level and site-specific level for the service. Local procedures reflected organisational policy in relation

to Ionising Radiation Regulations (2017). Ionising Radiation Regulations regulate the protection against exposure to ionising radiation because of work activity.

- Records showed all staff members signed to confirm they had read and agreed to abide by any new policies or procedures.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health.**
- Patients were sent information with instructions about fasting before the scan. Staff encouraged patients to drink water while waiting for the scan to support radiopharmaceutical uptake.
- Following the scan patients were offered a hot drink and biscuit prior to leaving the unit.

Pain relief

- **Staff monitored patients regularly to see if they were in pain.**
- Staff did not use a formal pain assessment tool but spent time checking the patient was comfortable during the procedure. Blocks and pillows were used to position the patient as comfortably as possible before the scan started. 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.
- There were no pain relief medications stored in the centre but patients were encouraged to bring pain killers with them to the scan if needed.

Patient outcomes

- **Managers monitored the effectiveness of care and treatment and used the findings to improve them.** They compared local results with those of other services to learn from them.
- Records showed that performance was monitored monthly. Areas monitored included incidents, training compliance, patient satisfaction and complaints.
- The service had an audit schedule. Records showed this included an annual infection prevention and control audit, a bi-annual policy audit, monthly reporting and image quality audits.
- The service sent 10% of reported scans for a quality control second reporting within the organisation. There were organisational discrepancy meetings in operation. This meant any concern regarding report quality was formally logged and shared with clinicians to ensure learning took place. Policies were in place to address any issues with the quality of scan reports, such as missing a problem which should have been reported.

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 monitor the effectiveness of the service.
- There was a central human resources department who managed the recruitment processes. The manager confirmed that all new employees had completed an enhanced disclosure and barring service check at recruitment. Employees completed health declarations for the occupational health department to review as well as other documentation including a new starter checklist, equality confidentiality and checks of personal radiation doses. Clinical staff had their professional qualifications checked at the time of recruitment. Annual professional registration checks were completed to ensure current registrations were in place. Following the inspection, we viewed three staff records which confirmed this took place.
- All staff at the centre received an annual appraisal and supervision. New employees had a three and six-month review in their initial six-month probationary period. We viewed three staff appraisals and two probationary reviews during the inspection which confirmed this took place.
- Each staff member maintained a paper file of training attended. This included mandatory training and competencies relevant to their role. We viewed two staff training files which confirmed records of the training and competencies.

Good

Diagnostic imaging

Multidisciplinary working

- **Staff of different kinds worked together as a team to benefit patients.** Doctors, radiographers, technologists and clinical assistants supported each other to provide good care.
- There was effective internal multidisciplinary team working that included centre staff and the wider organisation. Staff we spoke to described close and happy working relationships between all grades of staff.
- There was effective external team working. The centre was supported by staff from the neighbouring NHS trust with tasks such as cleaning, waste disposal and resuscitation.

Seven-day services

- The centre was open between 8am and 6pm on Monday, Tuesday, Wednesday and Thursday. The centre did not open at weekend.

Health promotion

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

Consent and Mental Capacity Act

- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.** They followed the centre's policy and procedures when a patient could not give consent.
- We observed staff obtaining and recording verbal consent from patients prior to providing care. Written consent was obtained before scanning and recorded on the patient data form.
- **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 ill health and those who lacked the capacity to make decisions about their care.
- Training on the Mental Health Act 1983 and Mental Capacity Act 2005 was included in the mandatory training provided by the provider.
- Staff told us if patients lacked capacity to make their own decisions, they would make decisions about care in the best interests of the patients and would involve their representatives and other healthcare professionals appropriately.

Are diagnostic imaging services caring?

Good

We rated it as **good.**

Compassionate care

- **Staff cared for patients with compassion.** Feedback from patients confirmed that staff treated them well and with kindness.
- We observed staff interacting positively with patients and those attending the appointment with them. Staff spoke to patients sensitively and appropriately depending on individual need. For example, a patient was supported to complete the required forms when they arrived for their scan.
- All staff wore 'hello my name is' badges, introduced themselves to the patients and communicated well to ensure patients fully understood. Patients were encouraged to ask questions and were given time to ensure they fully understood what was being said to them.
- Curtains were used appropriately to maintain privacy for patients in the uptake rooms.
- Patients were escorted to and from the examination rooms by clinical assistants who we saw being supportive and friendly.
- A privacy blind between the scanning room and control room was lowered while patients were being prepared for the scan.
- Patients were encouraged to provide feedback about the service. Feedback was used to monitor the standard of the care provided. All patients received an email link to an online organisational patient satisfaction survey. Patients could request a paper copy if required. The completion rate of the patient satisfaction survey was 16%.

Good

Diagnostic imaging

- Patients told us they were very satisfied with the level of care and compassion they received from the centre. For example, patients told us they preferred their scan to take place at this centre because of the friendly and caring staff.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- Staff provided support as required. We observed staff providing reassurance and comfort to patients. Patient comments within the satisfaction survey included being put at ease when they had felt extremely anxious. Patients told us that worries had been eased by the staff caring for them.
- We saw multiple posters displayed for patients who may have preferred a chaperone to accompany them. No formal training had been provided by the staff who were chaperones.
- The uptake rooms had relaxing scenes of tropical beaches and the scanning room had a ceiling scene of a sky to distract the patient during the scan. Each uptake room was temperature controlled and had a radio for patient comfort.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- Staff respected patient choices and delivered their care with an individualised patient centred approach.
- Patients and those close to them told us they had received information in a way they understood. Telephone conversations to book appointments were followed up with emailed information confirming the discussion. Patients were encouraged to contact the service with any concerns.
- Patients understood how they received the scan results. Posters informed patients to contact the centre if results had not been received as planned.

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 local people.**
- The service provided care and treatment for patients referred from the local NHS trust as part of a commissioned NHS England contract. The centre also scanned privately insured and self-funded patients.
- The waiting area was free from clutter, well lit, temperature controlled and had adequate seating available. It included a cold-water dispenser and hot drinks facility.
- The service opened Monday, Wednesday and Thursday from 8am to 6pm. Appointments could also be offered at the nearby Alliance Medical PET Diagnostic Imaging Centre in Maidstone to ensure patients had an appointment to suit them.
- Appointments were made by telephone and confirmed by email and letter. Information was provided about the scan and pre-scan preparations, directions and a map to the centre and contact details for queries.

Meeting people's individual needs

- **The service took account of patients' individual needs.**
- Car parking was available a five-minute walk from the scanning centre. There was a parking space to drop off patients just outside the front door. Step free access to the front entrance and an automatic door allowed accessibility for wheelchairs or patients with restricted mobility.
- There was a toilet available that was accessible with a dementia friendly seat and handrails. The toilet had an emergency pull cord to call for assistance. Patients could be accompanied by someone close to them if needed including during the PET-CT Scan. Dementia training was included in mandatory training for all staff.

- Ambulances transported patients from inpatient wards to the unit and transferred them onto the unit patient trolley. The unit was designed to be accessible to all. A patient transfer board was available for patients who required assistance transferring from their wheelchair or bed. All areas of the clinic were accessible to patients who required a wheelchair.
- Staff gave examples of supporting bed bound patients who needed a scan. They prepared the environment in advance to the meet needs of the patient and carers.
- A hearing loop was available for patients with a hearing impairment. An interpreter service was available for those who did not speak English as their first language. It was provided either via the telephone or an interpreter attended in person. There was a cordless telephone which could be taken into the scan room.
- Any worries such as a fear of enclosed spaces was assessed prior to scanning. Staff gave us examples of scans that had been simulated with patients to ensure that it could be tolerated.
- The scan machine could accommodate bariatric patients up to 28 stones in weight.
- There were leaflets available in the waiting area for patients to take. A safety instruction leaflet was provided for patients, or those close to them, to ensure safe management during the radioactive period following the scan. However, there was no information in alternative formats such as easy to read, braille or other languages.

Access and flow

- **People could access the service when they needed it.** Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- Audit records showed from March 2018 to September 2018 approximately 80% of patients had their scan and the results reported and with the referring consultant within 5 working days of the referral being received. The unit extended opening hours when required to ensure patients had their scan within five days of the referral being accepted. The reporting consultant nuclear medicine physician reported 90% of scans within two working days of the scan having taken place. Scan reports were available to the referring consultant via a secure electronic system.
- From March 2018 to February 2019, 1,892 scans took place. For the same period, 174 booked scans did not take place for a variety of reasons. This included patients who had forgotten the scan was booked, patients who were too ill to attend or had died, patient transport did not arrive, the scan was cancelled by the referring consultant, the patient's glucose level was unacceptable or the patient had not adhered to the preparation advice or the patient could not tolerate the scan. There were 22 scans cancelled for equipment failure.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**
- There were leaflets displayed in the patient waiting area to guide patients on how to provide feedback about the service.
- There was an organisational complaints policy which reflected national guidance. Records showed complaints handling and conflict resolution was included within the staff mandatory training. Staff told us they had received training in handling complaints and could describe the process.
- Learning from complaints in other locations was shared across the organisation using emailed minutes of meetings. For example, complaints had been made about scans cancelled on the day of the scan. The provider had changed practice and ensured patients understood that scans might be cancelled on the day due to failed radioactive medicines.
- The service had received one complaint from March to October 2018.We reviewed the complaint and found it was dealt with according to organisation policy.

Good

Diagnostic imaging

Are diagnostic imaging services well-led?

Good

We rated it as **good.**

Leadership

- **Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.**
- There was a clearly defined and visible leadership for the service. There was a unit manager who also managed the providers other local centre. Their time was divided equally between both centres.
- Centre staff understood the reporting structure and told us they were well supported by their managers.
- Senior managers told us they felt supported by the executives and they were approachable and contactable.

Vision and strategy

- **The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.**
- Staff could describe the organisational values of collaboration, excellence, learning and efficiency and told us it was at the heart of all they did.
- Staff appraisal was measured against the organisational values and action taken if their standard of work did not meet these standards.
- The vision and strategy of the organisation was displayed on the website and within the centre for staff, patients and visitors to see.

Culture

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- There was an open culture that encouraged incident reporting to learn from them and the improve the quality of care for the patients accessing the service.
- There was a positive attitude and culture where staff valued each other. Staff told us about excellent team working at all levels and a sense of pride providing continuity of care using a team approach.
- Managers told us they had the discretion to reward staff with pre-paid shopping cards or an increase of salary if they had worked above and beyond what would be expected.
- Staff notice boards showed social gatherings and seasonal activities took place. Staff told us they had an afternoon tea before their Christmas break. Staff told us this allowed them to get to know each other and bond as a team.
- All staff told us were passionate and proud about the care they provided for patients.

Governance

- **The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.**
- Twice yearly meetings took place for the integrated governance and risk board. Agenda items included review of previous minutes and outstanding actions. Presentations were provided by the clinical governance committee, information governance and security committee, radiation protection committee and health and safety committee.
- There were organisational polices as well as site specific procedures and processes including local rules and a radiation protection supervisor.
- As the centre had not been open a year the annual radiation protection audits were planned but had not yet taken place.
- There was a signed and dated service level agreement with the local trust to provide services such as cleaning, waste management, resuscitation and fire safety. The centre management met quarterly with the NHS trust to aid communication and had a good working relationship.
- Organisational level clinical governance meetings were held quarterly. Minutes of the meeting confirmed that representatives from this centre attended the meetings. The standardised agenda included a review

of previous meeting minutes and outstanding actions across the organisation. Items discussed and reviewed included incidents, patient experience, infection prevention and control, and policy updates.

- A monthly quality and risk report was produced by the provider to share details from other locations. This included any changes to CQC registered managers, training compliance, audit results, incidents including lessons learnt, staff radiation safety and infection and prevention control. Staff told us they read this regularly and could tell us of issues discussed in the most recent report.
- Subcommittees such as the radiation protection committee, clinical advisory committee, infection prevention and control, medical emergencies and medicines quality reported to the clinical governance meeting.

Managing risks, issues and performance

- **The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- There was an organisation risk register that contained risk assessments and an assessment of the risks posed and mitigation. This register was updated every two years and all staff had signed to say that had read and understood the register.
- There was a business continuity plan including backup systems in case of electrical failure. Staff told us this was held in the unit information folder.

Managing information

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- The service was aware of the requirements of managing a patient's personal information in accordance with relevant legislation and regulations. General Data Protection Regulations (GDPR) had been reviewed to ensure the service was operating within regulations.
- Information governance and data protection was included in staff mandatory training, 90% of staff had completed this training and could describe how to keep information safe.
- Consultant nuclear medicine physician
- Patient records were scanned and uploaded to a secure electronic system. Paper copies were kept in locked storage until their destruction after 30 days.

Engagement

- **The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.**
- Public engagement was mainly through interactions at the centre and via feedback from the patient satisfaction survey.
- Staff were updated on changes and events within the organisation through team meeting ensuring they were up to date. Lessons learned across the organisation were shared at this meeting.
- A quarterly communication was shared across the organisation from the managing director. This included details of lessons learnt to help drive improvement.
- Staff engagement was measured through an annual employee survey which was conducted by an independent organisation to ensure confidentiality. In response to the survey, action plans were developed and progress against the plans was measured on a regular basis.

Learning, continuous improvement and innovation

- **The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.**
- Records viewed during the inspection showed staff used their appraisals to identify areas for innovation and training to improve practice. These improvements could be supported by data system review and processes for evaluating and sharing results of improvement work such as quality control checks and quality audits.

Good

Diagnostic imaging

- Staff were supported to attend study days and conferences and shared innovations learned with the wider team.
- Staff innovation was rewarded with pay increases and pre-paid shopping cards.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12.— (1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (h)assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated; During inspection we observed that no staff cleaned their hands prior to patient contact and positioning equipment was not cleaned in between patient use. This meant we could not be assured that the service was controlling the spread of infection.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13.— (1) Service users must be protected from abuse and improper treatment in accordance with this regulation. (2) Systems and processes must be established and operated effectively to prevent abuse of service users. (3) Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

This section is primarily information for the provider

Requirement notices

During the inspection staff could not tell us what abuse was or how to escalate it once identified. This meant we could not be assured that services users were protected from abuse when using this service.