

Alliance Medical Limited

Southend PET-CT Centre

Inspection report

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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 had inspected this 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, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care to patients. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, 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 could access the service when they needed it and did not have to wait too long for a diagnostic procedure.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients to plan and manage services and all staff were committed to improving services continually.

However:

- The service did not have control and oversight of the environmental cleaning.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	This was the first time we had inspected this service. We rated it as good. See the summary above for details



Summary of findings

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Summary of this inspection

Background to Southend PET-CT Centre

Southend PET-CT Centre was run by Alliance Medical Limited. NHS England had selected a Collaborative Network, to provide PET/CT scanning services. Alliance Medical Limited was the lead service of the collaborative network.

Southend PET-CT Centre scanned their first patient in 2017 and they have grown significantly since then. They were seeing 13 patients a day initially, which had risen to between 16 and 19 a day in 2021.

Southend PET-CT Centre offered positron emission tomography- computerised tomography (PET-CT) scanning services. PET-CT scans combines a CT scan and a PET scan. A PET scan uses a mildly radioactive tracer to show up areas of the body where cells are more active than normal. They also offered Computerised Tomography (CT) scanning, a CT scan combines a series of X-ray images taken from different angles around the body. CT scan images provide more-detailed information than plain X-rays.

The centre offered scanning services 7.30am-7.30pm 7 days a week. They provided scanning service for both NHS and private referrals for adults over the age of 18.

The centre was a modular building on the site of Southend University Hospital.

The service had a registered manager in post and was registered for diagnosis and screening procedures. The centre had not been previously inspected.

How we carried out this inspection

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>.

Outstanding practice

We found the following outstanding practice:

- The local service had developed pictorial as well as written guides for staff which included correct equipment set up and the contents of the emergency trolley. The new guides provided a visual reference tool for the staff, so in an emergency, staff could quickly recognise and access equipment.

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action the 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 to improve:

Summary of this inspection

- The service should ensure that they have oversight of the environmental cleaning to provide assurance in the prevention of the spread of infections. (Regulation 12)






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 

This was the first time we had inspected this service. We rated it as 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. Staff we spoke with confirmed they were allocated time to complete training and were notified when training was due. The system operated on a traffic light system, green indicated training was up to date, orange indicated training was due and red indicated training was overdue. The training matrix on the day of inspection indicated 100% mandatory training compliance. Data provided by the location demonstrated the provider level expectation for mandatory training, including frequency, delivery method and staff groups requiring the training. Mandatory training included health and safety awareness, conflict resolution, manual handling, data protection and equality and diversity.

Clinical staff completed training on recognising and responding to patients with dementia. The service had developed a local competency for dementia training for the clinical staff and had shared this with the wider organisation.

Managers monitored mandatory training and alerted staff when they needed to update their training. The registered manager was notified via the traffic light system if any of the staff were due to complete or 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. Safeguarding adults level two was included in mandatory training for all staff who had direct patient contact including administration staff and level one for non-patient contact staff. This had a three yearly on line update training requirement. Safeguarding children level one was required for administration staff and level two for clinical staff. At the time of inspection there was 100% compliance.

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Staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with were able to describe what would constitute a safeguarding concern and could give examples of situations that would require a safeguarding referral. Staff knew who the safeguarding lead was and how to make a referral. The contact details for the local authority were clearly visible on the control room noticeboard.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment visibly clean.

Clinical areas were visibly clean and had suitable furnishings which were clean and well-maintained. The radiographers completed a daily checklist which included an equipment cleaning log and waste bag disposal. A review of the checklist demonstrated good compliance. However, there was a long handled duster, which was used by the radiographers for high level dusting, for example, the top of the scanner, stored incorrectly in the clinical supplies cupboard next to the sterile swabs. This was escalated and the manager provided evidence after the inspection that it had been removed and added to the agenda for the team meeting for learning. The patient rest cubicles had disposable curtains which were last changed 19 July 2021.

Environmental cleaning was provided by the trust twice a day. The cleaner would normally arrive in the morning and clean the 'hot' toilet as well as the rest of the general area. A 'hot' toilet is reserved for patients who have been given a radioactive substance and who are considered radioactive themselves. On the day of inspection they had not arrived and the radiographer contacted them to attend. As the 'hot' toilet had been used that morning it could not be cleaned until the following morning due to the radiation risk. This meant the toilet had not been cleaned since the day before. We could not inspect the toilet for cleanliness. The 'cold' toilet cleaning records were up-to-date and demonstrated that this area was cleaned regularly, however, the cleaning record for the rest of the department was poorly completed. The registered manager was aware the cleaning log was not always completed and it was flagged on the departmental audit programme. As a result the radiographers were asked to remind the cleaner to complete the log. The registered manager provided evidence after the inspection of the completed cleaning log.

The cleaning cupboard/slucce room contained a used mop and broom both of which appeared dirty, they were not hanging up but placed directly on the floor in the corner. The room was equipped with a clinical waste pedal bin. There were clean disposable mop heads available in the slucce cupboard, however, there were only blue mop heads available which are for general use. The registered manager provided evidence after the inspection that the used mop head had been removed. The registered manager confirmed after the inspection that the trust cleaner advised that they only used blue and red mops on the site. Red for toilets and blue for other areas. We were told the cleaning team usually bring their own cleaning trolleys with them. The registered manager was going to raise these issues with the Trust.

Staff followed infection control principles including the use of personal protective equipment (PPE). In the control room at each shift change the desk and computer keyboard was cleaned. Each staff member had their own pen (colour coded) which they keep in clear plastic pencil cases. IPC processes were followed throughout the day. All staff wore masks correctly, as well as, aprons and gloves as required. All PPE was disposed of properly in the correct waste bins. No bins were overflowing, and all were pedal bins.

Throughout the unit there were glove holders on the wall with selection of glove sizes and disposable aprons. Above each basin there was a sign about hand washing. The clinical lead shared a hand hygiene video the unit had developed.

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This demonstrated correct hand hygiene and was set to music. All staff, clinical and non-clinical participated in the creation of the video. It had been shared with other sites. Hand hygiene audits were completed monthly. The provider required the unit to complete at least two audits per month and the local target was five. During September 2021 the unit completed six hand hygiene audits, with no red flags.

The reception area had an automatic sensor alcohol gel dispenser. The seating was arranged to allow social distancing and there were social distancing floor markers. The receptionist sat at a desk with a clear plastic screen and wore a clinical face mask.

All staff were wearing correct uniform, including closed toe shoes. All staff were clean and tidy with long hair tied back.

All patients were cannulated prior to their scan. The company requires the unit to complete two cannulation audits per month. The unit completed four audits in September 2021 and four audits in October 2021. No significant issues were identified. All areas of learning were discussed at an individual level and at team meetings. We were unable to observe cannulation during inspection.

Staff cleaned equipment after patient contact. We observed equipment cleaning after each patient. In the scanning room the paper covering the bed was removed and disposed of. The scanner bed was cleaned thoroughly with clinical wipes. Any area the patient may have touched such as locked cupboard for their belongings was cleaned. They had a five minute gap between each patient to air the room and clean and dry properly.

The unit had a spill kit available in the event of a spillage of the radiopharmaceutical. Staff were able to demonstrate the location of the kit and had completed training on how to use it safely.

Environment and equipment

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

The service operated from a self-contained unit on the site of the acute hospital. The signage to the unit from the hospital car park was very poor and the unit did not feature on the hospital plan. The instructions given to patients on how to find the scanner by the unit were clearer, but the lack of clear signage made it difficult. The registered manager was aware of this issue and had raised it with the trust, and as a temporary measure, laminated arrows had been attached to the hospital corridors.

The unit had close circuit television monitoring (CCTV) in all areas which was overseen in the radiographers control room. There were signs throughout the unit to inform patients, staff and visitors that CCTV was in use. The radiographers used the system to monitor patients who were resting in the patient bays. The patients had call bells in the bays and toilets which the radiographer or clinical assistant would respond to if called. Testing of the call bell was part of the radiographers' daily checklist.

The design of the environment followed national guidance. The unit had to comply with regulatory standards relating to health and safety, radiation protection and the environment. The royal college of radiologists 'A strategy for PET-CT in the UK' August 2005 guidance states the facilities PET-CT units should include. The unit had all of the designated areas suggested including, a reception area with refreshment facilities, waiting room prior to injection, 'cold' toilet (for patients and staff prior to injection), injection area, laboratory for drawing up the radiopharmaceutical, 'hot' toilet (for patients post injection), hot waiting area, scanner room and control room.

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The 'hot' laboratory had a no entry and a radiation warning sign on the door. The door was keypad locked and the sealed sources were housed in a locked cabinet. The radiopharmaceuticals were delivered in sealed containers and the empty containers from the previous day, to allow for decay in the radiation level, were collected daily. The laboratory contained a laminar flow cabinet for the safe drawing up of the radiopharmaceutical. The local rules were clearly displayed on the wall. The local rules are the safe working practices required to restrict doses to individuals working in a radiation-controlled area, and any other persons who may be affected by the radiation in that area. The society of radiographers 'pause and check' poster was visible on the wall. The pause and check posters were published to serve as a reminder for radiographers carrying out examinations and is a shortened summary of the main checks required to comply with the ionising radiation medical exposures regulation (IR(ME)R) 2017.

Staff carried out daily safety checks of specialist equipment. The hybrid PET-CT/CT scanner had a comprehensive quality assurance programme. The daily quality control checks by the radiographers had three stages, a scanner warm up, check-up procedure, a CT quality check with a phantom and a PET quality check using a sealed source. The results were logged and a pass or fail was automatically generated. A review of the results log demonstrated all checks had been completed and all had passed. The scanner also had additional monthly checks which were carried out by the radiographers. The medical physics expert (MPE) from the local trust was contracted to conduct quarterly checks which included the calibration of the equipment and scanner and a review of the previous three months quality control checks. The MPE confirmed the quality assurance checks were set to national guidance, the national physics laboratory (NPL) good guide for the calibrator and the institute of physics and engineering in medicine (IPEM) report for the frequency of scanner tests.

The radiographers daily 'hot' laboratory tests included a check that the calibrator was not contaminated, sealed source checks and glucometer checks.

The radiopharmaceutical daily quality assurance checks were carried out by the production centre whilst the radiopharmaceutical was in transit. Once passed a release certificate was issued to the PET-CT unit.

The patient was not cannulated until all the equipment quality assurance checks were completed and the release certificate had been received.

The service had a maintenance contract with a specialist company for the servicing and repair in event of breakdown. The scanner was serviced every six months and the scanner itself flagged when it was due a service. A review of the equipment folder demonstrated completed handover forms as required by the ionising radiation regulations (IRR) 2017. In the event of a scanner breakdown the company could remotely access the equipment to diagnose the problem before an engineer was sent to the site.

The service had enough suitable equipment to help them to safely care for patients. The unit had three dedicated private patient rest bays, which were equipped with a reclining chair, cupboard, blankets, stool, hand sanitiser and clinical wipes. Patients could store their belongings in a secure locker in the rest bay and the scanning room. They also had a fourth bay which had a patient trolley bed, the *resuscitation* equipment, suction machine, blood pressure monitor and a wheelchair. All equipment was visibly clean.

The resuscitation trolley consisted of four drawers which were labelled, basic airway, advanced airway, circulation and fluids, drugs and miscellaneous. The trolley drawers were sealed with a numbered tab and this was recorded on the daily checklist. The daily checklist was reviewed, and the only gaps were when the centre was closed due to the pandemic. The drawers were opened for inspection and we checked expiry dates on consumables and medicines, and all were in date. The contents of each drawer were highlighted on information cards with both a written and pictorial

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description of each item for ease of checking and retrieving in the event of a cardiac arrest. The attached oxygen cylinder was checked and was full. The suction unit was clean and dust free and covered in a plastic cover. This was part of the trust's emergency equipment and was maintained and tested by the trust, however there was no record of the checks with the equipment.

The main corridor had a set of patients weighing scales as all injections were calculated using body weight. There was a BMI (body mass index) notice above the scales and a PAT (portable appliance testing) testing sticker on the scales from July 2021.

The scanning room had a locked storage cabinet to hold sterile equipment and supplies. A sample of the stores were checked and all consumables were found to be in date.

Staff disposed of clinical waste safely. The unit had appropriate clinical waste peddle bins all closed and were not over filled. We observed staff using the correct bins. The 'hot' laboratory had a dedicated sharps bin for the disposal of radioactive drawing up needles.

Assessing and responding to patient risk

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

Staff responded promptly to any sudden deterioration in a patient's health. Staff recognised and responded to patients who presented as acutely unwell during and on the findings from the scan. Patients who required urgent onward referral were managed in compliance with policy and local procedure. The radiographers were able to contact the ARSAC (Administration of Radioactive Substances Advisory Committee) license holder for advice or support with the PET-CT patients and the trust radiologists for CT patients. The trust emergency response team were able to be summoned in a medical emergency, for example if a patient had a cardiac arrest. Staff trained in intermediate life support were always on duty and would respond to any patient who became acutely unwell. During the previous year a patient had become acutely unwell while in the department and the trust emergency response team responded rapidly to the emergency call.

Staff completed risk assessments for each patient on arrival, and reviewed this regularly, including after any incident. All patients completed a patient data health questionnaire for PET-CT which included specific questions for female patients in the age range 12-55 to confirm they were not pregnant or breast feeding due to the radiation risk and medical history questions. The medical history questions included details about falls, claustrophobia, allergies, respiratory problems, surgery, diabetes and medicines however the form did not specifically ask about heart conditions and angina. A diagnostic scan can be a stressful situation for a patient, and stress can increase a patient's risk of angina and heart attacks.

All CT patients completed a contrast screening record form. This health questionnaire was to ensure the patient did not have any contra-indications to the CT contrast including allergies and renal function. CT Contrast is like a colourless dye and helps to highlight the areas of the body being examined.

Staff consistently followed the society of radiographer 'pause and check' checklist to ensure the right patient was having the right scan. We observed that patient details were checked at reception and again when called through to clinical areas where the patient was weighed. The patient was shown to a private bay and prepared for the scan. We observed two patients who were then taken into the scanning room and helped onto the scanning couch. A three-point confirmation of identity was again carried out by the staff.

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Staff knew about and dealt with any specific risk issues. PET-CT and CT scanning required the use of ionising radiation. The risk to the patient from ionising radiation was explained as part of the patient safety questionnaire and the patient received an information leaflet prior to the scan. The patient was asked to sign the form to confirm they understood the radiation risk. The employers IR(ME)R 2017 procedures for medical exposures in imaging were available and comprehensive. The local rules which were required to comply with IRR 2017 were on display throughout the unit, the local rules displayed were in date and version controlled. The unit had two radiographer radiation protection supervisors (RPS) and the staff duty rotas were co-ordinated so there should always be one on duty.

The service was supported by the local trust medical physics team who provided a radiation protection advisor (RPA) and medical physics expert (MPE). Good working relationships had been established and the medical physics and radiation protection advisors supported staff on site regarding sharing best practice and advice on safe delivery.

The unit had a robust system in place for visitors to the unit to inform them of the potential radiation risks and to check if there was any reason for the visitor not to enter the unit, for example pregnancy.

Staff shared key information to keep patients safe. The staff had a whiteboard on the wall, of the staff only area, which was clearly divided with the patients' names for that day, including the appointment time and any specific needs, for example, diabetes. The board included a task list, names of staff on duty and radiologist available for advice. The whiteboard was referred to during the course of the day to ensure the smooth running of the list. A daily huddle was held in the morning prior to the start of the list to discuss any concerns and to look at the patient list.

Staffing

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

The service had enough staff with an appropriate skill mix to keep patients safe. Managers accurately calculated and reviewed the number patients and could adjust the staffing level according to the type of scan and the number of patients. The regular 19 patient PET-CT list required three radiographers and one clinical assistant. A 24 patient CT list required two radiographers and one clinical assistant. The staff told us they always follow their safe staffing model and if they were short of a member of staff and a replacement was not available patients would be re-booked to maintain a safe service.

The service had low vacancy and staff turnover rates. The registered manager had increased the workforce in line with the increase in patient numbers and had not had a member of staff leave in the last three years.

The service had low sickness rates. The registered manager had no concerns with staff sickness and had not had to cancel patients due to staff sickness. Staff were given time to attend health appointments.

The service always had a radiologist on call including evenings and weekends. The PET-CT radiologists available were listed on the white board and the trust on-call radiologist was available for the weekend CT list.

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.

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The service used a secure electronic system, which was password protected, to maintain patient records. Paper records such as the booking forms and associated patient confidential information were scanned, uploaded to the electronic system and then securely shredded. All patient and clinical information was recorded on the organisation's electronic patient record system. A review of ten patient records confirmed all documentation was completed and scanned into the radiology information (RIS) system. The patient record could not be finalised on the RIS system if the 17 mandatory fields were not completed this included scan dose and operator.

The PET-CT scan images were uploaded onto the image transfer system and downloaded onto the alliance patient picture archiving and communication system (PACS) to be reported and stored. The CT scan images were directly downloaded into the trust PACS system via the image transfer system for the trust radiologists to report. Referring clinicians from the acute trust could access the electronic storage system for CT images. For referring clinicians who could not access the trust systems, the images could be burnt onto a disc.

Reports for the PET-CT scans were sent out electronically by email to the referring clinician.

Each staff member used a secure log-in to access the patient's information.

All booking referrals were received via electronic transfer and the administrative staff contacted the patient directly. Confirmation of the patient details and information was checked, and an appointment date agreed. Any additional information was recorded at that time, this included issues which may impact on the scan. Staff sent out an appointment letter by post with an information leaflet and this was followed up with an appointment reminder by email, letter or text.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. No controlled medicines were used or stored. Patient Group Directions (PGD) and Patient Specific Directions (PSD) were in use for the administration and use of contrast in CT scans. All staff were knowledgeable of the content. PGDs provide a legal framework that allowed the registered health professional to supply and/or administer specified medicines to a pre-defined group of patients without them having to see a prescriber (such as a doctor or nurse prescriber). PSD is an instruction to administer a medicine to a list of individually named patients where each patient on the list has been individually assessed by a prescriber.

CT contrast was supplied by the local trust. The unit records the batch, expiry and stock level on a spreadsheet. The trust replenishes stock on a Friday in preparation for the Sunday scanning list. The spreadsheet was reviewed and was fully completed and up to date.

CT contrast was stored in a locked cupboard in the scanning room and transferred into a warming cabinet on the day of the scan. All medicines were stored in temperature controlled locked cupboards. Thermometers were visible on the scanning room wall and in the locked cupboard. As part of the daily checklist the temperatures are logged to confirm that they are stored within the correct range, and staff were able to describe the action taken if temperatures were found to be out of range. The temperature checklist was reviewed and was complete.

The radiopharmaceutical was stored in locked transit cases. The patient dose was calculated dependent on the patient's weight. The daily record book was completed to include the tracer sticker from the transit case, time patient

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name and initials of staff dispensing. The day sheet on the day of inspection was fully completed when reviewed. The radiopharmaceutical was not prepared until the patient was cannulated so that there were no delays in the administration. Administration and dispensing of the radiopharmaceutical was authorised by the ARSAC license holder. We were unable to observe administration of the radiopharmaceutical during inspection.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses 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 knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy. Staff confirmed they knew how to report incidents and were able to give examples of the type of incident they would report. Staff were encouraged to report and record all incidents.

Managers shared learning with their staff and staff received feedback from investigation of incidents, both internal and external to the service. Staff told us if there was an immediate lesson learnt it was shared by the end of the day and shared with other staff via the team meeting and team huddle. Formal feedback and lessons learnt were shared at the staff meetings and included lessons learnt from incident at other sites. Staff who were unable to attend the staff meeting were emailed the minutes and had to acknowledge receipt. A review of the last three team meeting minutes confirmed feedback and lessons learnt were shared.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. The MPE confirmed that there was a reciprocal relationship for learning and a recent incident in the PET-CT had resulted in the trust also reviewing procedures. As a direct result of an incident the RPA with support of the registered manager had developed a radiation safety leaflet for the emergency response team and a new standard operating procedure for emergencies had been developed. Data supplied by the registered manager post inspection included a presentation from the RPA to share learning with other RPA's and MPE's.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff we spoke with understood the importance of duty of candour and a review of complaints and incidents demonstrated apologies and explanations were given to the patient where appropriate. Review of a recent incident demonstrated appropriate duty of candour and met the regulation requirement. Review of the corporate managers update bulletin demonstrated a requirement for staff to read and sign off the duty of candour policy.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The registered manager informed us all incidents including near misses were recorded for learning as well as investigation. The service had 12 reported incidents including four near misses from July 2021 to October 2021. Review of three incidents and investigation demonstrated patient involvement where appropriate, lessons learned and any further action required.

Managers debriefed and supported staff after any serious incident. The unit had a distressing incident on a Saturday. The registered manager informed us that support was offered to the staff immediately and counselling was requested for the staff. Data supplied by the registered manager post inspection confirmed on site group and individual sessions were facilitated by an external company.

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Are Diagnostic imaging effective?

Inspected but not rated 

We do not rate the effectiveness of diagnostic imaging services; however, we found the following during our inspection.

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 protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed policies, procedures and guidelines produced by the service. These were based on current legislation, national guidance and best practice, these included policies and guidance from professional organisations such as the Royal College of Radiologists and the Society and College of Radiographers (SCoR).

Patients had their needs assessed and their care and treatment were planned and delivered in line with evidence-based guidance, standards and best practice. The referral for each patient was assessed to ensure the scan requested was justified and within the unit remit and criteria. Justification was a requirement under the IR(ME)R 2017 regulations. Justification for CT scans was completed by the trust radiologists and for the PET-CT scans by the ARSAC license holders.

Staff were aware of the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R17). There were local rules and employer's procedures in place IR(ME)R which protected staff and patients from ionising radiation. Staff we spoke with were able to locate the relevant documentation and local Standard operating procedures, (SOP).

Staff completed a dose handling log. The records seen on inspection were completed. The staff managed a cohort of four patients each as the 'hot' radiographer before changing roles this reduced staff radiation exposure. All staff were monitored for radiation exposure using a personal dosimeter. If a member of staff received a dose there was an automatic trigger on the system if an investigation level was reached. The local Radiation protection supervisor (RPS) would conduct the investigation. The radiation protection advisor (RPA) issued an annual report.

Dose reference levels (DRLs) were displayed in the control room. A DRL is a specified radiation dose for a given imaging study that is not expected to be exceeded. If a radiation dose does exceed the diagnostic reference level for a particular study, this should prompt an investigation into radiographic technique or equipment performance. The clinical lead and RPS confirmed all patient doses were recorded. A review of five patient records confirmed the patient dose was documented.

There was an active programme of local audits including a review of patient safety questionnaires and a review of the patient log. Data supplied by the registered manager post inspection demonstrated full compliance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff routinely referred to any additional needs of patients. Staff we spoke with were able describe the correct process for best interest decisions when a patient was unable to give consent. All staff had additional dementia training

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as part of the mandatory training programme. Due to the nature of the service the patient needed to be able to cooperate with the scan and to lie quietly for the rest period and the scan. Procedures were in place for a comforter or carer to accompany a patient if required. We observed this during inspection. All additional support a patient required was discussed at the morning huddle.

Nutrition and hydration

Staff made sure patients did not fast for too long before diagnostic procedures. Patients were required to fast for six hours prior to a PET-CT scan and for a CT scan requiring contrast. Diabetic patients were flagged in the booking process and the fast period was reduced to four hours. Consideration was also given to the appointment time for diabetic patients.

All patients were given a drink and biscuits after the scan and encouraged to drink plenty of fluids to 'flush' out their system. Diabetic patients were encouraged to bring a packed lunch with them.

Patient outcomes

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

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment. Reporting guidelines and procedures were in place and there was an image quality audit which monitored the quality of imaging procedures. This ensured images were of optimal diagnostic quality according to current best practice. Data provided by the registered manager showed that for the year April 2020-March 2021 367 scans were audited and 99.9% were either grade five (perfect) or grade four (minor artefact, no impact).

All PET-CT images were reported in accordance with agreed local practice by the ARSAC license holders deliver accurate and effective radiological and clinical interpretation of images. The service had a specified report turnaround timescale, to ensure minimised delays for patients.

The CT scans were reported directly by the trust and were not part of the service's turnaround key performance indicator.

Managers shared and made sure staff understood information from the audits. Review of the team meeting minutes, and the audit log demonstrated the registered manager took appropriate action and shared learning from the results of internal and external audits.

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. The service operated a comprehensive mandatory and statutory training programme which ensured relevant knowledge and competence was maintained and updated throughout the lifespan of employment with the organisation. All radiographers were Health and Care Professions Council (HCPC) registered. On inspection we saw evidence of a radiographer completed and updated competency folder. The practitioner licenses for the PET-CT radiologists was available and reviewed.

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Managers gave all new staff a full induction tailored to their role before they started work. The clinical lead confirmed all new staff completed their e-learning within their first two weeks and had a personalised training based on previous experience. All new clinical staff had a competency book which had to be completed. We saw evidence of on-going competency sign off for a new member of staff.

Managers supported staff to develop through yearly, constructive appraisals of their work. The registered manager confirmed all staff had an annual appraisal. Data provided by the registered manager confirmed all appropriate staff had received an appraisal within the last 12 months. The registered manager had formal appraisals with the staff and set objectives which would be mandatory objectives, unit objectives and individual objectives.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The registered manager emailed the minutes of the staff meetings to staff who were unable to attend. Staff would then have to complete a signoff to acknowledge receipt.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The clinical lead had a structured approach to developing staff skills and competency. Staff told us they were given the time and encouragement to develop new skills.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. All clinical staff we spoke to were able to describe a training course that they had been able to attend as part of their continuing professional development.

Managers made sure staff received any specialist training for their role. The MPE provided update training for the staff. Staff had received fire drill training based around the scenario of radioactive patients. Fire safety and spill training was last held in July 2021.

Multidisciplinary working

Staff worked together as a team to benefit patients. They supported each other to provide good care.

Staff on site told us there was good multidisciplinary team (MDT) working with their colleagues. In addition, they had regular interaction with the trust MPE and RPA.

The unit provided training to the trust emergency response team and student nurses visited the department to observe PET-CT.

Seven-day services

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

The unit was open seven days a week 7.30 am to 7.30 pm. PET-CT was available Monday to Saturday and the unit provided a CT scanning service for the local trust on a Sunday.

Health promotion

Information leaflets about what to expect, how to prepare for their PET CT scan and the aftercare were sent to patients with their appointment letters.

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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.

The patient safety forms were completed by all patients prior to their scan. There were separate forms for PET-CT and CT scans. The PET-CT form required the patient to sign a confirmation that they had received an explanation of the procedure and wished to proceed. The CT consent form required the radiographer to sign to confirm the procedure had been fully explained and verbal consent had been given.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Staff had received training on mental capacity. Staff knew how to access the policy and guidance and who to ask for support.

Staff were aware of what to do if they had concerns about a patient and their ability to consent to the scan. Staff told us if, for example, a patient with a learning disability or a person living with dementia was due to attend, they would be advised to attend with a relative or carer to provide the necessary support. They said this information was usually available in advance. Staff we spoke with were able to describe the process for best interest decisions when a patient was unable to give consent.

Are Diagnostic imaging caring?

This was the first time we had inspected this service. We rated it as good.

Compassionate care

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

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. We saw staff were encouraging, sensitive and supportive to patients and those who accompanied them. Staff treated patients with dignity, kindness, compassion, courtesy and respect. We heard them introduce themselves prior to the start of a patient's treatment, explaining their role and what the patient was likely to experience during their appointment. We observed staff informing patients at frequent intervals of how long they had left during a scan. Staff made sure that patients' privacy and dignity was respected, we observed staff closing the scanner blinds to preserve a patient's dignity whilst moving from the scanner bed. Patients were advised on the most appropriate clothing to wear for the scan on booking which meant patients should not routinely need to change into a hospital gown for the scan.

Patients said staff treated them well and with kindness. A patient on the day of inspection confirmed staff were polite and kind, gave full instructions and treated them with dignity.

Staff followed policy to keep patient care and treatment confidential. There was signage on the wall in the administration office to remind staff about confidentiality and to ensure notes and records were correctly stored. We observed all staff locking computers when leaving their workstations.

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Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff were aware patients who attended the service were often feeling nervous and anxious. We saw how staff provided support, demonstrating a calm and reassuring approach to a nervous patient. We were told that patients known to be nervous or had additional needs were allowed to bring a relative or carer with them. Staff were knowledgeable on how they ensured the relative or carer's safety from any radiation exposure. The unit had a local initiative to give a birthday card signed by all the staff to any patient who had a birthday on the day they attended.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients who used the service were sent information in advance of their scan which included the date, time, scan type, examination preparation and duration and relevant radiation restrictions. Staff took the time to explain the procedure and what would happen during their appointment.

Staff talked with patients, families and carers in a way they could understand. Staff recognised when patients and their relatives needed additional support to help them understand. This included, for example, access to language interpreters.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service positively encouraged all patients to provide feedback. An email address was taken for the patient and a satisfaction survey sent to every patient. The company target was 10% however the service From April 2021 to September 2021 had a response rate of over 20%.

Patients gave positive feedback about the service. Data provided by the inspection manager after the inspection included positive feedback from patients which cited the quality of the care they received. The 'you said, we did board' had comments from patients which included "professional, knowledgeable and well organised."

Are Diagnostic imaging responsive?

This was the first time we had inspected this service. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of the people who used the service.

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Managers planned and organised services so they met the changing needs of the local population. The service had increased the number of available appointment slots by extending the hours of the scanning day as a response to increased demand for PET-CT scans. The service provided a CT scan service one day a week, for the local trust, to help relieve pressure on the local NHS service. In the event of a radioisotope failure, which meant PET-CT scans would need to be cancelled, the unit offered the free capacity to the local trust for CT scans.

Facilities and premises were appropriate for the services being delivered. The unit had sufficient comfortable seating, toilets and private rest bays. The unit was refurbished in response to patient feedback. Attention was paid to the comfort of the uptake chairs, secure locker for belongings during the scan and changing the music on offer. The unit created a 'your comfort' poster to encourage patients to ask for anything they needed to improve their experience.

The service was centrally located, near to public transport services and so was accessible to a range of people who may have opted to utilise transport other than a car. The unit was accessed via a slope which enabled patients with reduced mobility to use the services on offer.

Managers monitored and took action to minimise missed appointments and ensured that patients who did not attend appointments were contacted. The PET-CT patients had appointment reminders sent out to them via email, letter or text, staff told us this has reduced the number of patients who did not attend. Patients who failed to attend appointments were contacted by the service. Patient missed appointments and cancellations were discussed at the monthly team meeting.

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 had received training in equality and diversity and had a good understanding of cultural, social and religious needs of the patient and demonstrated these values in their work. Staff told us that a choice was given on the gender of the member of staff who assisted the patient. The service had an in-date, version controlled chaperone policy.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service planned ahead so that they could request a professional who can use sign language for hearing impaired patients when appropriate. The service had access to language line. The service arranged for the language line to explain the process to the patient by telephone.

The service had linked with the learning disability lead nurse at the local hospitals. The registered manager had asked them to assist in the production of new easy to read leaflets and communication aids.

Anxious patients and patients with dementia or memory loss could have a relative or carer with them for the resting phase of the procedure. They had reserved scan slots for patients living with dementia first thing in the morning so that they could reduce stimulus to the patient.

As a direct result from patient feedback the service had take-away coffee cups, and the patients now had the choice to have their hot drink and then leave the unit or to take it away with them.

Reasonable adjustments were made so disabled patients could access and use services on an equal basis to others. The service did not book patient transport but was able to direct patients on how they could arrange this.

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Patients were contacted by telephone to make the appointment, and any additional needs would be flagged by the referring clinician or raised on booking the appointment. Patients were encouraged to contact the unit if they had any needs, concerns or questions about their examination. There was a range of leaflets available, such as information about the scan, how the injection was produced and the aftercare.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to test and from test to results were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The PET-CT national contract stated 75% of referrals should be booked, scanned and reported on within five working days of receiving the referral and 95% within seven days of receiving the referral. Data supplied by the registered manager demonstrated that between January 2021 and September 2021 the service consistently exceeded both of these key performance indicators, with an average turnaround time of less than four days. The CT scans are booked and reported by the local trust the unit only provided scanning services.

The service checked the referring clinician was on the referral list and the form had been signed by the correct referrer. Every referral was justified by a radiologist before a patient was scanned. The service had some appointment slots reserved, for example, for urgent scans, private patients, patients with dementia and scans requiring a longer time slot. Patients were offered the first available appointment but there was flexibility for patient convenience and availability.

Managers worked to keep the number of cancelled appointments to a minimum. When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. PET-CT patients were given an information leaflet on the preparation of the radiopharmaceutical injection. The leaflet explained that if the injection did not pass the safety tests the scan may need to be cancelled. Any cancellations were re-booked for a time convenient to the patient. We saw evidence of oversight of this in the patient complaint log. Cancelled appointments were discussed at the monthly team meetings.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. All patients were asked for an email contact and a patient satisfaction survey was sent to them post examination. The information leaflets that the patients were given prior to the scan also detailed how to give feedback and how to make a formal complaint. The service website also detailed how to give feedback. The 'you said we did' notice board was clearly visible in the patient corridor and demonstrated to new patients that patient feedback was important to the service and actioned.

Staff understood the policy on complaints and knew how to handle them. All staff completed complaints handling training as part of the annual mandatory training programme.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff were able to describe how they dealt with face to face complaints or feedback, for example

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offering an apology, explaining to the patient how to make an official complaint and to log as an incident. All complaints received a written acknowledgement, the registered manager contacted the complainant by telephone and after the investigation an outcome letter was sent to the patient. Data supplied by the manager post inspection confirmed this process had been followed when responding to complaints.

Managers investigated complaints and identified themes. The registered manager welcomed feedback both positive and negative and saw this as a way to improve and develop the service. Patients who raised concerns on the patient satisfaction survey would be contacted by the registered manager. Data supplied by the registered manager post inspection demonstrated there had been two complaints between July 2021 and September 2021. There was a process for escalating the complaint if the patient was unhappy with the outcome of the registered manager's investigation.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff we spoke with confirmed feedback and learning from complaints was shared and discussed at the monthly team meetings. Review of the team meeting minutes from July 2021, August 2021 and September 2021 confirmed the registered manager shared feedback and learning.

Staff could give examples of how they used patient feedback to improve daily practice. The 'you said we did' board had examples of patient feedback and action taken, including the chairs, music and security of belongings. Patient feedback was received about patients feeling cold. Blankets were now routinely offered to patients during the rest period. We observed a patient in the scan room being prepared for their scan and they were covered with a blanket when they stated they were cold. Review of the team meeting minutes indicated the 'your comfort matters' poster would be amended to include if a patient was too hot or cold.

Are Diagnostic imaging well-led?

Good 

This was the first time we had inspected this service. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The Southend PET-CT Centre is part of the wider Alliance Medical group. There was a clearly defined management structure which was led by the managing director uk. The local manager reported to the regional head of operations, who then reported to the chief operating officer, who was responsible to the managing director.

The local leadership team consisted of a site manager and a clinical lead. The local leadership team had invested in key individuals to ensure the unit ran efficiently and safely when they were not on site. On the day of inspection, the registered manager and clinical lead were not onsite initially, however they arrived during the course of the inspection. The senior radiographer in charge, on the day, had received support and development and was efficient, competent and knowledgeable.

All staff we spoke to told us how the local leaders were visible and approachable. They told us they were comfortable to approach any member of the leadership team to seek support and help.

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The regional head of operations had a weekly call with the unit managers for support and updates. A bronze call was put in place during the covid-19 pandemic and had continued. This call included the unit managers and directors. The unit manager received a bi-monthly managers newsletter which had a reminder of actions and outstanding audits. The unit manager then disseminated the relevant information to the wider team. A review of three issues of the newsletter confirmed a key action point and time frame was included.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

The vision and strategy were developed at a corporate level. The patient was at the centre of everything they did. There were four measures to the company strategy, the mission or why, the vision or what they want to deliver, the strategy or how it will be delivered and the success or how measurement of achievement. The five values were openness at the centre and excellence, efficiency, learning and collaboration.

The company values posters were displayed in the unit staff room and each of the five values were explained in detail. Staff we spoke with were able to describe the values and the patient was at the centre of everything they did.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work.

There was a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. The service's culture was centred on the needs and experience of patients. The registered manager wanted to improve care for all patients, to make the unit feel less clinical and embed empathy with all the staff. This attitude was reflected in staff we spoke with on inspection.

Equality and diversity was promoted. It was part of mandatory training, and inclusive, non-discriminatory practices were part of usual working. The company had a freedom to speak up and whistle blowing policy and duty of candour policy which supported staff to be open and honest. A review of the September 2021 managers newsletter had a reminder for all staff to read and sign off these policies.

The local manager welcomed all feedback whether positive or negative and saw it as an opportunity to continually improve and develop the service provided.

Governance

Leaders operated effective governance processes, throughout the service. 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 company governance frameworks to support the delivery of good quality care. These came under the general governance of Alliance Medical UK.

The service undertook several quality audits, and information from these assisted in driving improvement and giving all staff ownership of things that had gone well. Action plans identified how to address things needed to be improved.

Local governance processes were achieved through team meetings and local analysis of performance, and discussion of local incidents. The service had monthly team meetings and all staff were expected to attend. There was a

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comprehensive standing agenda, which included quality and risk, information governance, health and safety, training and clinical lead update. The manager ensured team meeting minutes were shared with all staff through email. Staff who could not attend on the day signed team meeting minutes when they read them. Minutes referred to any actions from the previous meeting.

Feedback and actions of local incidents were shared with other units. Data supplied by the registered manager after the inspection confirmed this process.

Staff were clear about their roles and understood what they were accountable for. All clinical staff were professionally accountable for the service and care that was delivered within the unit. The minutes of the team meetings confirmed staff have the opportunity to discuss and learn from any issues raised.

The ARSAC registered reporting radiologists provided evidence of their approved scope of practice. The staff were able to access this information on inspection.

All new referrers had to be checked and agreed by head office. The referring consultants can delegate another doctor to make referrals, however, the delegated doctor is checked against the general medical council (GMC) register and the details are checked and agreed through head office before they are added to the referrer register.

The external MPE and RPA conduct regular audits to ensure compliance with IR(ME)R and IRR regulations to ensure staff and patient safety. Any actions arising are actioned by the unit manager and shared with the wider company.

There were policies and procedure in place for information governance and clinical record management.

Management of risk, issues and performance

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

There was a risk assessment system in place locally with a process of escalation to the corporate risk register. The local risk assessments were reviewed annually, or when there was a change to the risk status. The risk assessment worked on a traffic light system and included mitigation and control measures. Radiation safety had separate radiation risk assessments.

The local risk register had 16 identified risks and included a description, review date controls in place and person responsible. The risks identified were comprehensive and included manual handling, violence and aggression, infection and sharps injuries. There was corporate oversight of the risk register with automatic transfer to committee to review. The local risk register was reviewed and updated by the registered manager.

There was a corporate key point of learning update newsletter shared with the unit managers produced by the corporate quality and risk team. Review of the June 2021 newsletter included lessons learned and guidance.

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 submitted to external organisations as required.

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The service was aware of the requirements of managing a patient's personal information in accordance with relevant legislation and regulations. Staff viewed breaches of patient personal information as a serious incident. Information governance was part of the annual mandatory training programme for all staff.

The provider used a secure image transfer portal to upload the images for the radiologists to report. The system was password protected with a unique password for each user.

Electronic patient records were kept secure to prevent unauthorised access to data. However, authorised staff demonstrated they could be easily accessed when required.

Data supplied by the registered manager post inspection demonstrated a comprehensive programme of documentation shredding when no longer required, with retention periods, dates and responsibility.

The service consistently submitted notifications to the Care Quality Commission about changes, events and incidents that affected their service or the people who used it.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services.

Patients' views and experiences were gathered and used to shape and improve the services and culture. Patient surveys were in use, with the questions sufficiently open ended to allow patients to express themselves. Changes to the patient chairs and background music were as a direct result of patient feedback.

The company had an annual staff survey. A review of the 2020 experience at work survey demonstrated 69% participation response rate across the company. All areas had improved on the 2019 survey results, where direct comparison was possible.

Learning, continuous improvement and innovation

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

The clinical lead had developed pictorial as well as written guides for the staff to offer guidance from the correct equipment set up in the scanning room to what the contents of each drawer in the emergency trolley should look like.

The registered manager recognised the importance of positive feedback and named staff who received positive feedback from patients were acknowledged in staff meetings and rewarded. This innovation has been shared with the company.

The service understood that patients could attend for scans on their birthday and as a result they gave a birthday card signed by all the staff members.

As a direct result of learning from an incident they had created a radiation safety leaflet for the trust emergency response team.

The service had developed grab packs for the fire service in the event of an emergency with information on where the sealed sources were and contact telephone numbers.

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The registered manager encouraged staff to 'think outside the box' on how the service could improve the patient experience.