Alliance Medical Limited

South Tees 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?	Requires Improvement
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

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. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care to patients and made them comfortable. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available up to five days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. 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 felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- PET-CT national audit data for PET-CT scan turnaround times from 1 December 2020 to 30 November 2021 showed improvements were required.
- Staff were not confident when discussions took place about the 'Duty of Candour'.
- Permanent clinical staff had not completed level two adult safeguarding training relevant to their role.
- Some of the corporate policies reviewed were past their review dates.
- It was not clear that staff had completed sepsis training.
- A sepsis management policy was not available for staff to access.
- Staff were not aware of the Alliance Medical Limited strategy and vision for the service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	We rated it as good. See the summary above for details. We rated this service as good because it was safe, effective, caring, responsive and well led.

Summary of findings

Contents

Summary of this inspection

Background to South Tees PET CT Centre

South Tees PET-CT (Positron emission tomography–computed tomography) Centre is managed by Alliance Medical Limited (AML) which delivers diagnostic solutions in partnership with public organisations. The service is based in a modular building which can be accessed through the Endeavour Wing, James Cook University Hospital, Marton Road, Middlesbrough.

NHS England has selected a Collaborative Network, led by AML, to provide PET-CT scanning services across 30 locations in England. PET-CT is a directly commissioned service within NHS England. The service has a service level agreement in place with the NHS Trust to deliver positron emission tomography (PET) scanning services.

The procedure combines the pictures from a positron emission tomography (PET) scan and a computed tomography (CT) scan. The PET and CT scans are done at the same time with the same machine. The combined scans give more detailed pictures of areas inside the body than either scan gives by itself. A PET-CT scan is a specialist CT scan with an injection of radioactive isotope. The radioactive isotope injection shows up cells that are active either with disease or inflammation and can help the doctors focus on whether you need further investigations such as a biopsy.

South Tees PET-CT Centre in Middlesbrough specialises in the provision of services relating to diagnostic and screening procedures and services for people 18 years of age and over.

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

The PET-CT Centre is registered to provide the following regulated activity:

- Diagnostic and screening procedures

The PET-CT Centre has a manager registered with the Care Quality Commission (CQC).

This is the services first inspection since registration by CQC on the 25 July 2018.

How we carried out this inspection

The team that inspected the service comprised a CQC lead inspector and a specialist advisor with expertise in diagnostic and imaging services.

During the inspection visit, the inspection team:

- Visited the PET-CT Centre, looked at the quality of the overall environment and observed how staff were caring for patients.
- Spoke with the Registered Manager and Radiation Protection Supervisor.
- Spoke with three staff members.
- Reviewed seven patient care records and treatment records.
- Attended four patient consultations.
- Reviewed 50 policies, procedures and other documents which related to the running of the service.

Summary of 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.

Areas for improvement

Action the service MUST take to improve:

- The service must ensure that permanent clinical staff complete level two adults safeguarding training relevant to their role and attend updates every three years. Regulation 18(2)(a)

Action the service SHOULD take to improve:

- The service should ensure that staff are updated with the 'Duty of Candour' so they are confident in its application.
- The service should ensure that all corporate policies past their review dates are updated.
- The service should ensure that staff can access sepsis training.
- The service should ensure that staff can access a sepsis management policy.
- The service should ensure that it continued to improve the PET-CT scan turnaround times.
- The service should ensure staff are aware of and involved in the Alliance Medical Limited strategy and vision for the service.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Diagnostic imaging

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

Are Diagnostic imaging 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.

During inspection we reviewed the ionising radiation training policy (v1.1). The policy outlined the mandatory training for all staff, dependent on role, who were either engaged in work with ionising radiation or directly concerned in the work with ionising radiation. For example, The essentials of positron emission tomography–computed tomography, introduction to radiation protection and radiation protection supervisor training.

Staff were introduced to and had read the positron emission tomography–computed tomography scanners local rules on induction to the service and following updates to the local rules.

Managers monitored mandatory training and alerted staff when they needed to update their training. The training needs analysis showed the description of training, staff groups the training applied to, frequency and whether the training was online or face to face.

Staff training records confirmed completion of mandatory training subjects in 2020/21. Some of the mandatory training sessions completed included: Ionising radiation (medical exposure) regulations online training, PET-CT Specific Classified Worker Medical training, manual handling, conflict resolution, infection prevention and control, fire and complaints.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had some training on how to recognise and report abuse and they knew how to apply it.

The Medical Director held the ultimate accountability for safeguarding for the service.

Identified safeguarding service leads for children and adults safeguarding were in place and the staff had the contact details for the NHS Trust safeguarding teams.

Comprehensive safeguarding adults and children's policies and procedures were in place and due for review in October 2021. The policies outlined the objectives, explained the terminology of various types of abuse, identified the duties, roles and responsibilities of staff.

The corporate Alliance Medical Limited (AML) safeguarding policy and AML permanent staff training needs analysis for mandatory training identified all clinical staff complete level two and / or three adults and / or children's safeguarding training relevant to their role and attend updates every three years.

The intercollegiate document Adult Safeguarding: Roles and Competencies for Health Care Staff (2018) competency framework identified that all practitioners who have regular contact with patients, their families or carers, or the public should complete level two safeguarding training.

Staff training plans confirmed that all clinical staff had completed level one adult and children's safeguarding training sessions. The adult safeguarding training agendas also included training on the Mental Capacity Act. None of the three eligible staff appeared to have completed level two safeguarding training.

The South Tees PET-CT centre standard or clinical operating procedure (issued 30 October 2021) for safeguarding adults and children identified staff at this centre were required to complete level one training as part of their mandatory training only. Discussions held with staff confirmed that no children's or young people's scans were undertaken at this site.

Staff knew how to make a safeguarding referral, identify adults at risk of, or suffering, significant harm and worked with other agencies to protect them. No safeguarding incidents had taken place.

Disciplinary policies and procedures were in place.

Recruitment practices included completion of disclosure and barring (DBS) checks. Staff said that three yearly reviews of enhanced disclosure and barring checks were completed.

Staff said patients were protected from discrimination including discrimination in relation to protected characteristics under the Equality Act. The Equality Act covers the same groups that were protected by existing equality legislation – age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity. Equality and Diversity training statistics confirmed 100% staff attendance in 2020/21.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The service had adapted its IPC policy and introduced COVID-19 standard operating procedures to keep staff and patients safe.

The registered manager was the infection, prevention, and control (IPC) lead. The service had links with the microbiology service of a local NHS trust.

Staff completed infection, prevention and control training as part of the mandatory training.

There were no incidences of a healthcare associated infection in the last 12 months.

Good

Diagnostic imaging

Initial entry to the service was through the Endeavour Wing reception area where seating was spaced apart to conform with COVID-19 guidance. Floor signs indicated the importance of social distance and hand sanitisers were visible throughout the Endeavour Wing reception area and the PET-CT unit.

Initial key COVID questions were asked as part of the patient's telephone booking. On arrival patients were asked a series of COVID related questions and staff were informed of the results of patients COVID risk assessments.

Staff followed Public Health England guidance on personal protective equipment which was sourced from Alliance Medical Limited (AML). Control measures such as hand washing facilities, hand gel, aprons and gloves were available. Staff had bare arms below their elbows.

The unit was visibly clean, furnishings were clean and well-maintained, and staff cleaned equipment after patient contact. The NHS Trust cleaned the portacabin on the mornings following the scanning day and the quality of cleaning was audited by the trust. For 2021 the monthly average compliance score which resulted from the cleaning audits was 98.04%. Cleaning schedules were recorded in the diary daily and were divided into daily and weekly tasks.

Full compliance was noted against the monthly hand hygiene audits; monthly and bimonthly peripheral vascular devise audits.

The IPC annual audit and COVID Secure audit was completed by the quality and risk assessor. The IPC audit undertaken on the 25 January 2021 compliance score was 99%, no concerns were noted.

Legionella Testing was completed on 8 July 2021. The premises were identified as low risk and some actions were identified for completion, for example, a legionella awareness course should be completed. Staff said the low and medium rated actions were being completed.

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 design of the environment followed health building note (HBN 6) national guidance.

Service facilities included one hot lab/dispensing room, one scanning room, a control area, two injection rooms, a cubicle space which could accommodate a trolley and one wheelchair accessible hot toilet. On the day of inspection, the cubicle space was used by staff as a small office /staff change area.

CCTV operated at the unit to aid the safety of patients and staff.

Radiology signs were seen on entry to the unit and displayed on the PET-CT scanner door.

The service had enough suitable equipment to help staff care for patients safely.

Out of hours specialist support was available for scanner problems and unit maintenance.

South Tees PET-CT Centre local rules were approved on the 5 November 2021. The local rules contained information which identified the radiation protection adviser (RPA) and the radiation protection supervisor (RPS). The RPS was the clinical lead for the unit. The names of staff were documented once they had read the local rules.

Good

Diagnostic imaging

Records showed that equipment was serviced regularly and planned preventative maintenance had taken place. The GE710 scanner was serviced twice yearly, its last service was on the 9 June 2021 and it was identified as fit for use.

Annual radiation monitor assessments and recalibration took place in 2021.

The radiation protection supervisor completed two audits in 2021; all areas were compliant.

Staff did daily safety checks of specialist equipment and records were seen confirming this.

Staff checked the defibrillator and resuscitation grab bag contents monthly. The contents checklist from October to December 2021 included equipment and medicine expiry dates and confirmed all was in order. Anaphylaxis and diabetic kits were also in the bag. Random checks of these medicines confirmed they were in date. Paediatric resuscitation equipment was available.

Staff said the radiation room risk assessments were kept in the site file and on the services intranet SharePoint system. The latest three risk assessments were dated 1 July 2021 and were reviewed yearly by the RPA. These risk assessments centred on the PET-CT Scanner and control room, the radiopharmalogical storage and preparation areas and injection rooms, toilets, connecting corridor.

The building and the radioisotope storage box were lead lined. The radioisotope box was stored in a secured area. Staff said lead gowns and screens were not used in the unit.

The Environmental Agency permit for radioactive substances activities was in place.

A sealed source leakage test took place on the 8 December 2021 and a pass rating awarded.

The last staff film badges monitoring report confirmed ongoing monitoring took place. Film badges were replaced at the beginning of each month. Finger shields are available for use when drawing up the radioisotope doses.

Control of Substances Harzardous to Health (COSSH) substances were stored on a shelf in the locked staff toilet.

Spillage kits, arrangements and decontamination procedures were in place. Monthly spill kit audits took place. We saw audits documented from August to December 2021 and no issues identified. Discussions with staff confirmed a knowledge of how to deal with spillages. A spillage protocol was seen and if a spillage occurred staff would complete an incident form.

The PET-CT environment was subject to monthly health and safety audits which were all compliant, the last audit took place on the 1 December 2021.

Staff disposed of clinical waste safely and arrangements were in place for waste management and collection.

Assessing and responding to patient risk

Staff identified, responded to and removed or minimised risks to patients. Staff identified and quickly acted upon patients at risk of deterioration.

Daily safety huddles took place at 07.30 hours; we saw the outcomes of two safety huddles documented on the safety huddle documentation.

Good

Diagnostic imaging

The service could access a medical physics expert; the radiation protection adviser and radiation waste adviser were based in another NHS Trust. The clinical lead was the designated radiation protection supervisor. We saw evidence that their advice was followed through local rules procedures, risk assessments and minutes of joint service review meetings with the trust three monthly.

Pregnancy checking procedures were in place and pregnancy posters displayed throughout the unit. We saw a radiation risk assessment had been completed dated 10 July 2015 for any pregnant members of the resuscitation team. Information for female employees and risk assessments were also completed when needed.

In a medical emergency staff would call the NHS Trust resuscitation team and transfer the patient to the main unit of the local NHS Trust.

Cardiac arrest and medical emergencies procedures were available for staff to access. Do not attempt resuscitation and the deteriorating patient guidance was present in the medical emergencies policy as recommended by the Resuscitation Council and applied to common medical emergencies.

Staff said and training records confirmed that trained clinical staff had completed immediate life support training; whilst reception staff had completed basic life support training. Discussions with staff confirmed they were confident about their resuscitation skills.

Staff said sepsis training was completed as part of their mandatory infection control training. We asked about the sepsis management policy and staff were unable to confirm the service had one.

Patients and visitors completed the PET-CT patient data form which was a safety screening questionnaire to ensure they were suitable to be scanned and enter the PET-CT environment.

Patients with more complex needs who may require sedation were notified by the referrer.

Staff ensured that referrers acted on urgent or unexpected findings through completion of the urgent pathology checklist and contact with the Administration of Radioactive Substances Advisory Committee (ARSAC) consultant radiologist who was based at the hospital. Staff said images were sent to the AML head office who sent them to the ARSAC adviser to report on. Staff said this process had not been required during the last three years.

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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service operated three days per week and was staffed by a senior radiographer who was the clinical lead, clinical assistant and a second radiographer. The registered manager was onsite for one day a week as they also covered another site. Staff said that staffing was appropriate to demands and lone working did not take place.

Daily staffing levels included two radiographers, one clinical assistant and a receptionist. We saw the 'Your team for today' board identified this information.

The service could access a medical physics expert; a radiation protection adviser and radiation waste adviser. The clinical lead was the designated radiation protection supervisor.

Alliance Medical Limited ensured out of hours support for the unit was provided by mobile managers and information technology. The local NHS Trust would also provide support if needed. Senior staff which included the registered manager could be accessed by staff for help if needed.

Seasonal pressures were managed centrally by the bookings department and the safety huddles alongside daily calls assessed capacity.

In the event of sickness safe staffing levels were maintained through support from a mobile team, and if required staff came to assist from another centre. Staff said the only temporary staff used was a receptionist.

Qualification checks such as General Medical Council, Allied Health Professionals checks were carried out prior to employment. The 'IRMER Referrer, Practitioner and Operator List' confirmed radiographers and doctors' qualifications.

Records

Staff kept detailed records of patients' care and diagnostic procedures. Records were clear, up to date, stored securely and easily available to all staff providing care.

Records were stored securely.

Information security standards were met, and password protected systems are used.

We saw a mix of paper records and electronic records in use. Patients records were recorded electronically on the Trust information system which allowed sharing of information.

Patient information was shared when an inpatient was scanned, or a medical emergency happened. Electronic sharing of patient information and patient images took place. In the case of a medical emergency the patient data form was shared with the next team responsible for the care of the patient, and all in-patients received guidance post scan.

Radiology results were reported via the radiology imaging system.

We reviewed seven patients records which included the patient data form. The information identified was completed; this included the patients' medical history, baseline weight and height, medication and confirmed the patient's agreement to the scan and use of their PET-CT scan information. Information specific to female patients aged between 12 – 55 years was also collected. The patient data form also identified the scan details.

Records audits took place. Compliance was 80% and 90% respectively for the two referral audits reviewed. The shortfall related to the full referrers details not being present. The referrers were contacted and asked to ensure they completed this information going forwards.

Medicines

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

The Alliance Medical Limited (AML) medicines quality policy and procedure (for review July 2021) outlined the pathway and process of medicine management, as well as respective roles and responsibilities.

Good

Diagnostic imaging

The medical director had overall responsibility for the management of medicines and diagnostic agents in use at Alliance Medical facilities including the methods of administration, and for ensuring that requirements of all relevant legislation was met. The medical director obtained assurance through governance structures and chaired the medicine's quality committee. An external pharmacy advisor supported national requirements.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Administration of radioactive substances advisory committee (ARSAC) licences were seen for the ARSAC Consultant who staff said was easily contactable.

All administrations of radiopharmaceutical were performed under the written authorisation of an administration of radioactive substances advisory committee (ARSAC) license holder or their delegate as appropriate. An ARSAC licence holder was always available when the service was operational.

A list of staff who gave radioisotopes was available. Staff received radionuclides training on induction.

Radioactive isotope storage was secured within locked lead lined cabinets in a secure room.

Patients were weighed on arrival to the unit.

Radioisotopes were only drawn up once the patient was present and calibration checks had been completed and passed.

Staff checked that they had the right patient prior to giving the radioisotope.

Prior to giving the isotope staff told the patient what to expect and that it was important for the patient to reduce movement following the injection of the isotope.

The medicines grab bag audits from October to December 2021 identified no concerns.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Alliance Medical Limited central governance oversaw trends and incidents through the Clinical Advisory Committee and Quality and Risk Team. We saw that lessons learnt were discussed at clinical governance and staff meetings and circulated to staff through the Risky Business newsletter.

Staff said there were no incidents in 2021. Should there be a radiation incident staff said they would contact the radiology protection adviser or medical physics expert and record the incident on the incident reporting system. The registered manager would investigate the incident and share any learning or changes to practice with the wider team.

We asked staff about 'Duty of Candour' and when it would be used. All the staff we spoke with had some knowledge of the 'Duty of Candour' but did not appear confident in its application.

Good

Diagnostic imaging

South Tees PET-CT incident register confirmed four incidents from 1 April 2019 to 14 May 2021. We saw evidence of investigation, lessons learnt, and actions taken from these incidents.

No never events were reported by the service during the 12-months before inspection. Never events are serious patient-safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death, but neither need have happened for an incident to be a never event.

Are Diagnostic imaging effective?

Inspected but not rated

We currently do not rate effective for diagnostic screening services.

Evidence-based care and treatment

The service provided care and procedures 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.

The service had identified and kept up to date with changes in clinical guidance through guidance provided through the Clinical Advisory Committee, Health Safety Committee, Radiation Protection Committee, Education Learning and Training Committee and Information Governance Committee.

Where people were subject to the Mental Health Act (MHA) the service ensured compliance with the MHA through support from their referring clinician. In these cases, more time was given to support the patient and escorts accordingly.

We reviewed the written examination protocols which should be available to the radiographer's use; however, these were not dated, reviewed or seen to be agreed by the consultant. We reviewed the same protocols on the providers 'SharePoint' intranet which were agreed and dated and had been reviewed every two years.

We observed that some corporate policies were past their review date. Integrated governance and risk board meeting minutes and information governance and security committee minutes confirmed that an ongoing process of review was in place to update policies and procedures.

Nutrition and hydration

Staff made sure patients did not fast for too long before diagnostic procedures. Staff considered patients individual needs where food or drink were necessary for the procedure.

Staff said patients were sent information about fasting.

People with diabetes were advised to bring food with them.

All patients had blood sugar levels checked and recorded on arrival to the centre.

Water was available via a water cooler for patients and staff.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff said they did not give pain medicines at the PET-CT Centre. To alleviate any discomfort staff positioned patients using pillows and a wedge and checked that patients were comfortable and ready to proceed.

Patient outcomes

Staff monitored the effectiveness of care. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant* clinical accreditation schemes.

The service was accredited by the Quality Standard for Imaging (QSI). QSI was designed to be applied within an imaging service for the purposes of quality improvement. It articulated the expectations of good imaging, international radiology and teleradiology services. It reflected wide consultation and valuable comments and suggestions received from professional colleagues and relevant UK government agencies and regulatory bodies. The accreditation was ongoing.

The Medical Physics Expert completed yearly audits; the last audit identified no actions on the 9 June 2021.

The last Radiation Protection Adviser audit took place on the 14 May 2021 and identified recommendations which were implemented.

Monthly dose reference level audits took place and the dose reference levels were displayed in the control area. We reviewed the dose reference levels and noted that they were below national dose reference levels.

Throughout 2021 monthly image quality scores audits confirmed image quality. In November 2021 the yearly image quality report confirmed where images fell below standard. A total of 254 scans were audited from 2333 scans. The audit outcome identified that three scans were graded two and three which staff said were investigated and actions implemented.

The radiation protection supervisor completed two audits in 2021 and all areas were compliant.

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 attended a three-month induction which included the corporate induction at the Alliance Medical Limited head office. A comprehensive local induction checklist took new staff through key milestones identified on day one, the first week and during their first month. As the new staff member progressed through the induction checklist they and their manager would sign and date to confirm each area was achieved. Familiarisation with equipment formed part of the induction.

Staff said informal daily staff supervision took place and competency assessments were signed off by the radiation protection supervisor.

Good

Diagnostic imaging

In 2020/21 staff said they had an annual performance review. Following the inspection, an undated completed staff appraisal log was provided as evidence for those staff who worked at the PET-CT Centre. The appraisal log confirmed the staff had their annual appraisals.

To help staff understand patients' needs in areas such as cancer, dementia and delirium they completed training in these areas three-yearly.

Staff were allocated three hours of continuing professional development time monthly.

Monitoring of staff registration was through relevant professional bodies.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Quarterly meetings with the local NHS Trust took place as part of the service level agreement Results of patients' scans were returned to the referrer.

All work list management was discussed on a weekly call with the Administration of Radioactive Substances Advisory Committee.

Seven-day services

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

The service generally operated three days per week for from 08:30 to 5pm. However, staff said there were occasions when the unit had operated for up to five days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

If patients required further guidance, they were advised to discuss directly with their radiologist / referrer.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff had completed annual mandatory training in consent processes and the Mental Capacity Act. Discussions with the staff confirmed their understanding in these areas.

Consent was obtained from the patient or respective power of attorney representative at the time of the booking and at the time of the appointment.

If an inpatient had a do not attempt cardiopulmonary resuscitation (DNACPR) decision staff could access this information in their records. Outpatients would bring the DNACPR document to their appointment so that staff were aware of their wishes in this area.

Good

Diagnostic imaging

Where an adult attended a scan and lacked capacity or the radiographer was concerned the patient may lack capacity and there was no clear directive from the clinician regarding consent, the examination was delayed until consent was verified. The referrer completed a 'Consent form: For patients who lack capacity to consent to Investigation or treatment' in line with AML consent policy.

Two consent audits were undertaken in 2021 which included a review of 10% of referrals for the month. The outcomes of both audits confirmed 100% compliance against checks that the patient data form had a signature consenting to the examination required.

Are Diagnostic imaging caring?

Good

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.

We spoke with three patients who were satisfied with their experiences throughout the scan process. Two patients told us they were extremely happy with the service from start to finish.

Patient engagement feedback allowed reflection on outpatient comments with a view to improve the imaging service delivery. At the time of the appointment or on the day of the scan patients were advised to provide an email address so that an AML electronic satisfaction survey was sent following completion of the procedure. The aim was to maintain the confidentiality of their feedback; this could also be provided in a written format or verbally.

Family and Friends test results from the 1 November 2021 to the 30 November 2021 identified high satisfaction levels (over 90%) by patients for their overall experience, appointment booking, and information provided at the booking. Over 90% said they would recommend the service to family and friends. Staff said they would continually self-evaluate monthly survey outcomes to ensure a good patient experience.

Patients could be escorted if it is considered essential to the success of the scan and in cases where patients had additional needs.

We observed five patient interactions from admission to the unit to their discharge. Staff ensured patients were comfortable, completed pre-investigation checks and explained what was happening. Staff were respectful and the patients 'dignity was maintained.

Emotional support

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

We observed five patient interactions from admission to the unit to their discharge. Staff kept patients informed about the process and explained what was going to happen.

Good

Diagnostic imaging

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

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.

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.

Following an explanation of the procedure and its aim patients were asked to consent for the scan. This information was repeated at the time of the patients scan to ensure that informed consent was achieved.

Information leaflets were available for patients, for example: PET-CT – A guide to your scan. This information leaflet could also be accessed via the alliance Medical Limited (AML) website. The leaflet was in different formats, written, pictorial and video to allow for the adult and/or child's understanding. The information included what the scan was, how to prepare for the scan and what to expect during and post scan. Patients were advised they could provide feedback of their experience through completion of a patient questionnaire or by contact with the customer care department.

Patients could access frequently asked questions on the AML website.

COVID-19 information, pregnancy and scan information were available for patients to read on arrival at the unit. Information was available in different languages.

Patients could request a chaperone and the use of chaperones poster was displayed to inform patients of this option.

Are Diagnostic imaging responsive?

Good

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 local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The service provided positron emission tomography (PET) computerised tomography (CT) scanning services to the NHS.

The service generally operated for three days; however, staff told us that on occasion the service would operate four or five days when required.

Six slots are reserved within diaries every week to work with a new initiative of upper gastrointestinal PET scans for the NHS Trust.

Good

Diagnostic imaging

To improve the service the tracer had been implemented in the treatment of prostate scans, on Thursdays. Trust referrals can be scanned locally now rather than travel to another NHS hospital.

An application was made through the Administration of Radioactive Substances Advisory Committee for another tracer licence to enable the scanning of patients' brains. This will ensure that patients do not need to travel to Newcastle for this scan.

Monitoring of service delivery against contractual agreement took place with the local NHS Trust.

Facilities and premises were appropriate for the services being delivered.

Patients could park close to the main entrance of the unit.

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. They coordinated care with other services and providers.

Accessible information standards were applied to the service. One example of how this was achieved was by signposting the patient to the online PET-CT video. This informed the patient of about the procedure and what to expect.

Patients were offered a variety of location options based on their address location and appointment choices.

The facility is Disability Discrimination Act compliant and a dedicated trolley bay acts as a waiting area for bed bound patients.

Hearing loops were available for patients and visitors.

Interpreter services could be arranged to support communication.

For those patients who have additional needs including complex communication needs additional time was factored into the appointment.

Visually impaired patients and any patient requiring assistance could be escorted.

Use of chaperones information was displayed in the main corridor and available to patients.

Staff completed equality and diversity, dementia and delirium training to enable them to better understand patient's needs.

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.

The service at South Tees was a scan only service for mainly NHS patients.

Good

Diagnostic imaging

Patients bookings took place through their consultant's secretary. Alliance Medical Limited (AML) bookings team sent the patient referrals to the Administration of Radioactive Substances Advisory Committee consultant radiologists to determine any contraindications for the scan and then returned the referrals to the AML bookings team.

The process included the patient contact by phone, the scan appointment letter was sent, and the patient was booked in and their details entered onto the radiology information system. Staff rechecked the referrals and booking list on the morning patients were due.

The radiation protection supervisor contacted the referrer if they needed to see the scan urgently.

The service level agreement with the NHS Trust confirmed the contractual expectation on reporting times. Radiology reporting fell within the local NHS Trusts accountability. Time standards were identified on page 34 of the service level agreement. The time standards, (i) and (ii) indicated that scans without critical or urgent findings would be returned by 12 noon on the second business day after receipt of the images, unless they were a cardiology or neurological scan, in which case it was three business days. Urgent finding timeframes were also indicated as one hour for the draft report and 12 business hours for the final report to be sent to Alliance Medical Limited.

The contractual agreement with the local trust identified diagnostic test waiting times must be within six weeks of referral for a diagnostic test. These waiting times were monitored monthly and average referral to scan times for South Tees PET Centre from April to October 2021 ranged from under 6 days to two days. The referral to scan times were seen to have decreased to two days from July to October 2021.

PET-CT National audit data for PET-CT scan turnaround times from 1 December 2020 to 30 November 2021 showed improvements were required, against the average national turnaround time of 4.77 days.

The data provided for South Tees PET-CT Centre confirmed the following PET-CT scan turnaround times: 50.9% (1237 scans) met national turnaround times with turnaround times between less than three to four days.

37.3% (906 scans) had turnaround times between five to seven days, whilst, 11.8% (287 scans) had turnaround times of over seven days.

Alliance Medical Limited audited its own reporting service. The May and November 2021 reporting audits was on all examinations involving ionising radiation to ensure a report was available on the radiology reporting system. Both audits were 100% compliant.

Urgent cancer appointments and referrals were seen within the national average of seven days and were accommodated in a full diary by utilising one reserved slot, released the day before.

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.

Good

Diagnostic imaging

If any direct or indirect service user wished to provide feedback the Alliance Medical Limited comments, compliments and concerns patient guide was provided to inform them how to verbally log their feedback with any member of staff. Guidance on how to log a formal written complaint was also provided and recorded in the service incident management system for investigation. The results of a complaint investigation were shared with the complainant by letter.

The service had a formal complaints register in place. During the last 12-months staff said they had received two complaints, both of which were now closed.

Staff had received many compliments from patients and to recognise this the directors of AML had written achievement letters to acknowledge the complements received.

Are Diagnostic imaging well-led?

Good

We rated it as good.

Leadership

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

Senior leaders said there had been no impact on leadership capabilities during COVID. Managers from across the region stood in and took responsibility for the service in the absence of the unit manager.

The site generally operated three days a week. During that time the registered manager was on site one day. The clinical lead radiographer was on site for the three days the service operated.

Board members included the medical director, managing director, non-executive directors, operations director, commercial director, and finance director.

Business continuity plans were in place and all leaders were aware of all services in case they needed to cross cover for each other in an emergency.

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 focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to apply them and monitor progress.

The provider had developed a 'strategy wheel', a tool to show staff how the organisations values linked to the mission, vision, strategy and success. Staff learnt about the core values at the corporate induction.

The corporate strategy identified 'putting patients at the centre of everything we do'. Discussions with staff confirmed they were not familiar with the corporate strategy.

Alliance Medical Limited values were displayed in the unit corridor and were identified as openness, collaboration, excellence, learning and efficiency.

Within the company strategy document the aim set against the value was clearly stated, for example for openness – 'We act with transparency and honesty in everything we do, where staff are encouraged to speak up to ensure a safe and secure environment for our patients.'

We saw that each value had a specific aim identified against it and reasons identified for 'Why? What we want to achieve? How?' were identified. Success measurements against these values were captured through patient satisfaction, clinical audit, for example, image quality and the availability of individual patients reports within a seven-day period from booking to the report being available.

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 and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff said Alliance Medical Limited had identified a freedom to speak up guardian (FTSUG). The FTSUG poster directed staff to contact telephone details for the FTSUG. Staff said the managing director had sent weekly communications to staff in which they asked staff to contact them with any concerns. Staff were unable to name the actual FTSUG.

The company strategy value of openness encouraged staff to speak up to ensure a safe and secure environment for patients.

Staff were encouraged to raise concerns with their line manager and speak out when they saw something wrong.

We observed that the team were a cohesive team who worked well together.

Staff said they felt supported by the registered manager and described him as 'a great manager, very approachable, kind to staff, thinks totally about welfare'.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Information governance management across Alliance Medical Limited (AML) was coordinated by the Information governance and security committee.

The clinical advisory committee and quality and risk team oversaw trends and incidents.

Staff reported incidents through the incident reporting system and all incidents were recorded. In 2020/21 there had been no incidents.

Clinical guidance was followed, and local policies and procedures reviewed to ensure guidance was current. Some local corporate policies had recently passed their review dates and we saw through meeting minutes reviewed that AML recognised this and appropriate actions were being taken to update these policies and procedures.

The annual audit plan ensured standards were assessed, and actions identified where performance fell below accepted practice.

During 2020-21 the AML audit plan identified two biannual, six monthly and nine annual audits. The outcomes from these audits showed high levels of compliance which ranged from 88% (quality assurance review audit) to 100% (10 audits).

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The managing director had overall responsibility for the strategic and operational management of Alliance Medical Limited (AML), including the effective management of strategic, operational and clinical risks across the AML.

The director of quality and risk was responsible for reviewing the overall status of clinical risk and reported to the International Team on behalf of the senior management team quarterly.

Risk was a standard agenda on all governance meetings.

A summary of the health and safety incidents, trends and actions were part of the monthly senior management team agenda and were also reviewed at the Health and Safety Committee.

The 'Risky Business' newsletter informed staff of incidents and lessons learned business wide.

An assurance framework and local risk register were in place. This generic framework included individual risk assessments, controls, assurance and gaps in assurance which could be applied to diagnostic centres.

Alliance Medical Limited (AML) monitored scan turnaround times (TAT) and breach times and identified that TAT continued to be a daily priority. One point raised at the AML North East service review meeting on the 30 November 2021 recognised the 'continued increase in referral demand is receiving additional focus with the recovery plan being reviewed on a weekly basis.' This resulted in improved turnaround times, despite increased referral volumes in October 2021.

The registered manager was the infection, prevention, and control (IPC) local point of contact. Changes to IPC policy and procedure were disseminated through this group and the wider leadership teams.

The June 2021 radiation protection advisers report and the medical physics expert's 'The Ionising Radiation (Medical Exposure) Regulations 2017' audit recommendations were actioned.

Diagnostic imaging

Annual reviews took place of three risk assessments by the radiation protection adviser. These risk assessments dated 1 July 2021 centred on the PET-CT scanner and control room, the radiopharmalogical storage and preparation areas, injection rooms, toilets, connecting corridor.

Relevant cascade alerts were cascaded to the relevant teams and appropriate actions were taken and confirmed.

There had been no issues relating to staff performance.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Alliance Medical Limited (AML) completed their annual self-assessment of compliance against the Department of Health information governance policy and standards via the Data Security and Protection Toolkit. The self-assessment in June 2021 for the 2020/21 NHS Digital Data Security and Protection Toolkit was “standards met”. They were also reaccredited with Cyber Essentials in October 2020. (Alliance Medical Quality Account 2020 - 2021)

The senior information risk owner was one of the executive team.

The AML Nominated Individual was the Caldicot guardian.

All staff had completed data protection training.

Staff accessed the electronic patient record system via secure smart card access; patient information was encrypted and sent using a secure account.

Staff identified no data breaches over the last 12-months. If one occurred, it was reported via the incident reporting system.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Patient engagement surveys collated patient feedback on their imaging experience. The monthly patient satisfaction survey results from November 2020 to October 2021 showed high levels of satisfaction (384 patients). Throughout this time period six patients described a poor experience whilst one patient described their experience as unsatisfactory.

Monthly staff meetings took place.

Good

Diagnostic imaging

The 2020 experience at work survey results showed improvement compared to previous years. The survey results were shared with the senior operational leadership team for their respective areas for consideration of any regional actions. Improving manager skill and confidence, understanding and addressing discrimination and harassment matters were highlighted as an important area of focus and was to be taken forward by the human resource team.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

There was no evidence of quality improvement.

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 18 HSCA (RA) Regulations 2014 Staffing The service must ensure that permanent clinical staff complete level two adults safeguarding training relevant to their role and attend updates every three years. Regulation