PET CT at The Harley Street Clinic

Quality Report

154 Harley Street
London
W1G 7LJ
Tel: 0207 725 6801
Website: www.theharleystreetclinic.com/molecular-imaging-PET CT

Date of inspection visit: 8th January 2019
Date of publication: 19/03/2019

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Not sufficient evidence to rate
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

PET CT at the Harley Street Clinic is a private medical imaging service that comes under the general management of The Harley Street Clinic but has a separate registration.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 08 January 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's

Summary of findings

needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

The main service provided was positron emission tomography–computed tomography (PET CT) and diagnostic computerised tomography (CT).

Services we rate

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

We found the following areas of good practice:

- The service managed staffing effectively and services always had enough staff with the appropriate skills, experience and training to keep patients safe and to meet their care needs.
- There were systems, processes and practices essential to keep patients safe identified, put in place and communicated to staff.
- There was an effective system in place for reporting incidents. Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses.
- Relevant and current evidence-based guidance, standards, best practice and legislation was used to identify and develop how services, care and treatment were delivered.
- Staff had the right qualifications, skills, knowledge and experience to do their job.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.
- Staff communicated with patients to ensure that they understood their care, treatment and condition.
- People could access the service when they needed it.
- Leaders had the skills, knowledge, experience and integrity to manage the service.
- There were governance frameworks to support the delivery of good quality care.

However, we also found the following area in which the service needed to improve:

- On the day of inspection, staff were initially unable to locate the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 Employers Procedures to show to inspectors. These regulations set out a list of procedures required as a minimum in any radiological installation. They ensure staff understand their individual roles and responsibilities in procedures.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Dr Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good	The provision of PET CT scanning services, which is classified under the diagnostic imaging and endoscopy core service was the only core service provided at this service. We rated this core service as good overall. • There were systems, processes and practices essential to keep patients safe identified, put in place and communicated to staff. Care records were written and managed according to best practice. • In most cases, relevant and current evidence-based guidance, standards, best practice and legislation was used to identify and develop how services, care and treatment were delivered. • Information about the outcomes of patient's care and treatment was routinely collected and monitored. There were governance frameworks to support the delivery of good quality care.

Summary of findings

Contents

Good

PET CT at The Harley Street Clinic

Services we looked at
Diagnostic imaging

Summary of this inspection

Background to PET CT at The Harley Street Clinic

PET CT at The Harley Street Clinic is operated by Pet Ct LLP. The service opened in May 2008 and provides computerised tomography (CT) and PET CT diagnostic services for adults. The unit is registered with the CQC to undertake the regulated activity of diagnostic imaging.

There has been a registered manager in post since June 2011.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and a specialist advisor with expertise in radiological services. The inspection team was overseen by Head of Hospital Inspection Terri Salt.

Information about PET CT at The Harley Street Clinic

PETCT at The Harley Street Clinic LLP offers positron emission tomography–computed tomography (PET CT) and diagnostic computerised tomography (CT).

PET-CT scans combine PET (positron emission tomography) and CT (computed tomography) technology in one full body scanner. This advanced nuclear imaging technique shows how the cells in the body are functioning at the same time as generating 2D and 3D images of inside the body. PET-CT scans can be used to diagnose and monitor cancer, to see if cancer has spread to other parts of the body, and to assess response to treatment. They can also be used to diagnose inflammatory conditions and heart conditions. For the PET part of the scan, an injection of a substance called a radioactive tracer is administered. As this is absorbed by the body, any cancerous or inflammatory cells will show up on the scan as hot spots. The CT scan produces 2D X-ray images of the body as it moves through the scanner. These can be layered to create 3D images for the consultant to analyse.

Patients are seen on an appointment basis and come from the UK and overseas. PET CT is offered to adults over the age of 18 as well as children of all ages. We were told that children made up a very small proportion of the patient group, with between six and ten seen per year.

The centre is open between 8.30am and 6:30pm Monday to Friday. Prostate-specific membrane antigen (PSMA) clinics are run on occasional Saturdays.

The lower ground floor consisted of a hot lab, which is a specially designed room for nuclear medicine where the radiopharmaceuticals are delivered, stored and prepared for dispensing; a scanner room and a control room. There were also two patient toilets (one with disabled access), two patient changing rooms and five treatment cubicles. In addition, there were two store rooms, one staff toilet, a housekeeping cupboard and plant room.

Four patient cubicles were equipped with an automated armchair and one with a patient trolley for those patients too ill to sit up. All cubicles had an entertainment system. The reception area was on the ground floor. The mezzanine floor included a radiologist reporting room, office space and an IT equipment room. There was a bed lift between the ground and the lower ground floors.

During the inspection, we visited all areas of the centre. We spoke with 11 members of staff including; chief executive officer, head of imaging, deputy imaging manager, radiologists, superintendent radiographers, radiographers and nuclear medicine technicians.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12

Summary of this inspection

months before this inspection. This was the services first inspection since registration with CQC, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (October 2017 to September 2018)

- In the reporting period (October 2017 to September 2018) there were 2,447 positron emission tomography–computed tomography (PET CT) scans performed at the service.
- The service employed a deputy imaging manager, two senior radiographers, six nuclear medicine technologists and 2.6 imaging office administrators.
- Seventeen radiologists worked at the service under practising privileges.
- The radiation protection adviser was appointed under contract from a local NHS acute trust.
- Controlled medicines were not used and therefore they did not have an accountable officer for controlled drugs (CDs).

Track record on safety

- No Never events
- Clinical incidents: two no harm, 13 low harm, zero moderate harm, zero severe harm, zero death
- No serious injuries
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA)
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-Coli
- There were four complaints between September 2017 and September 2018 which went through the formal complaints process and all were upheld
- No Radiation Medical Exposure Regulations (IR(ME)R) notifiable incident between October 2017 and September 2018

Services provided at the hospital under service level agreement:

The provider had a number of service level agreements which included:

- Clinical and non-clinical waste removal
- Confidential waste removal
- Water safety and water risk assessments
- Chemical and hazardous waste material removal
- Chemical supplies
- Biomedical maintenance
- Fire alarms and firefighting equipment
- Laundry and cleaning services

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- Staff received effective mandatory training in the safety systems, processes and practices.
- There were systems, processes and practices essential to keep patients safe identified, put in place and communicated to staff.
- Standards of cleanliness and hygiene were maintained.
- The design, maintenance and use of facilities and premises prevented patients from avoidable harm.
- There were comprehensive risk assessments carried out for patients who used services and risk management plans developed in line with national guidance.
- There were sufficient numbers of staff with the necessary skills, experience and qualifications to meet patients' needs.
- There was an effective system in place for reporting incidents. Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses.

However, we also found the following issue that the service provider needed to improve:

- Staff were unable to unable to direct us the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R17).

Are services effective?

Not sufficient evidence to rate

We do not rate effective for this type of service.

We found:

- Relevant and current evidence-based guidance, standards, best practice and legislation was used to identify and develop how services, care and treatment were delivered.
- There were systems in place to inform staff of any amendments to policies or procedures.
- Information about the outcomes of patient's care and treatment was routinely collected and monitored.
- Staff had the right qualifications, skills, knowledge and experience to do their job.
- Staff were appropriately involved in assessing, planning and delivering patient's care and treatment.
- Information leaflets such as understanding your PET CT scan were sent to patients with their appointment letters.

Summary of this inspection

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.

Are services caring?

Good

We rated caring as good because:

- Staff understood and respected patient's personal, cultural, social and religious needs, and took these into account.
- Staff understood the impact that a patient's care, treatment or condition had on their wellbeing and on their relatives, both emotionally and socially.
- Staff communicated with patients to ensure that they understood their care, treatment and condition.

Are services responsive?

Good

We rated responsive as good because:

- Patients' individual needs were accounted for. Staff delivered care in a way that took account of the needs of different patients on the grounds of age, disability, gender, race, religion or belief and sexual orientation.
- People could access the service when they needed it.
- Patients we spoke with told us they knew how to make a complaint or raise concerns about the service. Complaints were responded to in a timely way.

Are services well-led?

Good

We rated well-led as good because:

- Leaders had the skills, knowledge, experience and integrity to manage the service.
- The provider had a clear vision and a set of values for what it wanted to achieve and workable plans to turn it into action.
- The leadership team promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- There were governance frameworks to support the delivery of good quality care.
- There was a risk assessment system in place locally with a process of escalation onto the corporate risk register.
- Electronic patient records were kept secure to prevent unauthorised access to data however authorised staff demonstrated they could be easily accessed when required.
- The service gathered patients' views and experiences and used these to shape and improve the services and environment.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Not rated	Good	Good	Good	Good

Good

Diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good.

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Staff received effective mandatory training in the safety systems, processes and practices. At the time of inspection, 100% of staff were compliant with their mandatory training. This met the compliance standard expected by the service.
- Training was delivered as a mix of face to face and e-learning modules.
- All clinical staff who supported patients as part of the clinical pathway were required to complete immediate life support (ILS), and intermediate life support. All but one staff member was fully compliant with their ILS training. We saw evidence that this person was booked to do their training within two weeks of this inspection. Non-clinical staff completed basic life support (BLS) and were 100% compliant with this.
- We were assured that staff working with radiation had appropriate training in the regulations, radiation risks, and use of radiation. Staff could provide evidence of training and were aware of the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 Employers Procedures.
- However, they were unable to locate information regarding the patient identification procedure and the pregnancy questioning procedure. We were subsequently directed to them by the deputy manager, who told us they would reissue directions to staff and streamline the access process.
- A contemporaneous training record was available for all staff and was reviewed each month by the deputy manager. Staff were emailed to prompt them to book to update their training.
- Mandatory training subjects included:

- Ethics and code of conduct.
- Fire Safety.
- Health and Safety.
- Mental Capacity Act (MCA) and the Deprivation of Liberties.
- Safeguarding Children Level 3.
- Safeguarding Adults Level 2.
- Basic Life Support.
- Intermediate life support.
- Paediatric Basic Life Support (PBLS).
- Infection control.
- Equality and diversity.
- Moving and Handling.
- General Data Protection Regulation (GDPR).
- Infection Control and Sepsis.

Safeguarding

- **Staff had training on how to recognise and report abuse and they knew how to apply it.**
- There were arrangements in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Staff were trained to recognise adults at risk and were supported with an effective safeguarding adults' policy in place that

reflected relevant legislation and local requirements. Staff we spoke with demonstrated they understood their responsibilities and adhered to safeguarding policies and procedures. Staff were aware of their responsibilities surrounding female genital mutilation (FGM).

- There were processes in place to ensure the right person received the right imaging procedure or radiological scan at the right time. The service checked three points of identification and used the society of radiographers pause and check guidance. An audit of checks completed between July and September 2018 showed there was 90% compliance with this. It was acknowledged that this was an area for improvement and we saw in team meeting minutes that staff were reminded of the necessity to perform this check for each patient.
- All clinical staff were trained to safeguarding children level 3 and level 2 for adults and had access to a designated safeguarding lead in another part of the organisation.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well.**
- Standards of cleanliness and hygiene were maintained. The service had infection prevention and control (IPC) policies and procedures in place which provided staff with guidance on appropriate IPC practice; for example, communicable diseases and isolation.
- There were reliable systems in place to prevent and protect patients from a healthcare-associated infection. There were safety systems, processes and practices in place and these were monitored and improved when required. The infection lead contributed to site infection control policies and training.
- There were no incidences of a healthcare acquired infection between October 2017 and September 2018.
- There was a robust cleaning schedule in place. The staff team cleaned the scanning rooms at the end of each day. Cleaning was recorded on a daily check sheet which was reviewed by the unit manager each week. We observed there were appropriate cleaning procedures in place for all PET CT equipment following use.
- In addition to the daily clean, there were monthly and quarterly deep cleans which included removal of contents from store cupboards and trolleys, as well as defrosting of fridges. We saw evidence to assure us this had been completed.
- We observed staff to be compliant with best practice regarding hand hygiene, and staff were noted to be bare below the elbow. There was access to hand washing facilities. We observed staff washing their hands using correct hand hygiene techniques before, during and after patient contact.
- Hand sanitiser gels were available in reception and in all rooms. Information charts about hand hygiene were displayed throughout the service. The service met National Institute for Health and Care Excellence (NICE) QS61 statement 3: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care.
- Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO) 'Five Moments for Hand Hygiene.' These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene to reduce risk of cross contamination between patients.
- The provider told us 20 hand hygiene observations were done per month and submitted data which showed there was 100% compliance with hand hygiene between September 2017 and September 2018. Hand hygiene results were communicated to staff at team meetings and through email.
- The provider submitted data on other infection prevention and control observations carried out between September 2017 and September 2018. These included bare below the elbow practice; environmental and equipment checks; peripheral vascular disease insertions and sharps.
- These audits were 100% complaint other than the bare below the elbows audit which dropped to 67% in one month (August 2018). We discussed this during inspection and were told this related to two members of staff, and had since been addressed. The provider submitted data following inspection which showed that there was 100% compliance with bare below the elbow practice for October and November 2018.
- Sharps disposal bins (secure boxes for disposing of used needles) were located across the service which ensured the safe disposal of sharps, such as needles. They were all clean and not overfilled. We saw labels were correctly completed to inform staff when the sharps disposal bin had been opened.

Good

Diagnostic imaging

Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
- The design, maintenance and use of facilities and premises prevented patients from avoidable harm.
- The PET CT department was on the lower ground floor and was accessible by lift as well as stairs. Access to clinical areas were protected with doors secured with a keypad entry system.
- Maintenance and use of equipment protected patients from avoidable harm. Equipment we looked at had an up-to-date service record which provided information on when an item was due to be serviced.
- The provider submitted data following inspection which showed their annual checks of the lead apron and lead thyroid collar ensured they were safe to use, with no visible cracks or deterioration. We saw there was 100% compliance between January and December 2018 of monthly checks of spill kit contents, syringe shields, hot lab shield and lead transport box.
- The centre was completely refurbished in 2017 and fitted with a digital PET CT scanner which offered improved lesion detectability in smaller nodules, a reduction in CT dose without compromising imaging quality and reduced scan times for longer imaging procedures.
- PET CT was also equipped with a radioisotope patient automatic dose dispenser. This machine was out of service for the two months prior to this inspection. In the meantime, staff told us they reverted to manual dispensing.
- A control room area allowed visibility of patients at all times during their scan.
- There was sufficient space around the scanner for staff to move and for scans to be carried out safely. Patients had access to an emergency call buzzer, ear plugs and defenders during scanning, music of the patient's choice could be played. A microphone allowed contact between the radiographer and the patient at all times.
- The provider submitted an audit of quality assurance (QA) checks between July and December 2018 which showed there was 100% compliance. The audit recorded that there was daily QA of the PET CT scanner including the CT warning lights checks. PET calibrations were performed every two weeks between July and December. Other QA checks included in the audit were the blood glucose meters and dose calibrator, all of which were 100% compliant.
- Arrangements for managing waste and clinical specimens protected patients from avoidable harm. This included classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste. Staff used the correct system to handle and sort different types of waste and these were labelled appropriately.
- The systems, processes and practices that were essential to prevent patients from avoidable harm were identified, put in place and communicated to staff at team meetings and through e-mails. Implementation of safety systems, processes and practices were monitored and improved when required.
- All equipment conformed to the relevant safety standards and had been regularly serviced. Electrical equipment had been appropriately tested.
- Resuscitation equipment was readily available and easily accessible. We saw daily and weekly checks were carried out which confirmed the equipment was safe and fit for use. There were procedures in place for the transfer of a patient from the scanner in the case of a medical emergency.
- There were arrangements in place to restrict access and control the area where there was ionising radiation. We saw radiation warning signs were correctly located outside the clinical diagnostic imaging area. Signs on the door explained safety rules. A warning sign lit up over the door when the PET CT was in use.
- Chemical products deemed as hazardous to health were in a locked cupboard and accessible only to authorised staff.
- Emergency pull cords were available in areas where patients were left alone, such as toilets and the treatment room. Call bells were available within the scanning machine which patients could press if they wanted the scan to stop.
- There were two unlocked medical storage trolleys in the controlled clinical area. The trolleys contained medical supplies which included safety enabled cannulas, medical tape, plasters, gloves, swabs, needle free valves, straws and tourniquets. Following inspection, the

provider confirmed that a recent risk assessment showed no further control measures were required as the current control measures were sufficient to mitigate potential risk.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient.**
- The provider had a policy designed to identify the deteriorating patient and guidance for escalating treatment and care. We saw evidence of a patient safety questionnaire being completed prior to any scan.
- Risks were managed positively and updated appropriately where the patient's condition required this. For example, where a patient was claustrophobic or had a needle phobia, there was opportunity for the patient to attend the service in advance and meet with staff and examine the scanning machine.
- No patients required urgent transfer for emergency care between October 2017 and September 2018.
- Staff used The Society of Radiographers (SoR) 'pause and check' system. Pause and check consisted of the three-point checks to correctly identify the patient, as well as checking with the patient the site/side to be imaged, the existence of previous imaging and for the operator to ensure that the correct imaging modality is used.
- Clinical staff told us they felt confident to identify and respond appropriately to changing risks to patients who used the service, including deteriorating health and wellbeing or medical emergencies. All clinical staff had received immediate life support training and were able to describe the process to follow for those clinically unwell patients who required hospital admission.
- The provider had an imaging reporting policy (awaiting final ratification at the time of inspection) which included communication of critical, urgent and unexpected significant radiological findings.
- Radiologists explained the process to escalate unexpected or significant findings both at the examination and upon reporting. They told us how urgent or unexpected clinical findings which required urgent management were shared via telephone call to the referring consultant directly as a matter of extreme urgency.
- The service ensured that women (including patients and staff) who were or may be pregnant always informed a member of staff before they were exposed to any radiation in accordance with IR(ME)R. Pregnancy and breast-feeding questionnaires were filled in for all female patients aged between 12 and 60 years old. Information about the impact of treatment on pregnancy was sent out to the patient at the time of booking the appointment. There were notices up in the reception and waiting area requesting that patients notified staff if they were unsure about whether they were pregnant.
- The service had named staff fulfilling the essential roles of radiation protection advisor (RPA), medical physics expert (MPE), radiation protection supervisor, senior radiologist and infection control lead. Staff said the radiation protection advisor (RPA) and the medical physics expert (MPE) were readily accessible online or through over the telephone for providing radiation advice. The MPE visited the service every two months.

Radiographer staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- There were sufficient numbers of staff with the necessary skills, experience and qualifications to meet patients' needs.
- The provider employed radiographers and molecular imaging technologists. Staffing included a deputy molecular imaging manager, two senior molecular imaging radiographers and three molecular imaging technologists. There were 1.6 whole time equivalent (WTE) imaging office administrators at the time of this inspection.
- All staff working at the service were expected to complete the local induction process that covered local requirements, such as: knowledge of the local rules document, fire evacuation plan, local staff facilities and access codes to relevant areas. We saw that a copy of the local rules was signed by agency staff in the department on the day of this inspection.
- All new agency staff members were oriented around the PET CT department on their first day and provided with a local induction package. This listed competencies to be assessed before the staff member could work under supervision. We saw one such induction booklet which was signed off by a permanent member of staff.
- One agency member of staff told us their competencies in, for example, peripherally inserted central catheter

(PICC) and implanted central venous access devices, as well as scanning, were formally assessed. They then shadowed a permanent member of staff for three days before they could work independently. Agency staff had to work under direct supervision when treating paediatric patients.
- The provider used agency staff as required. These were from the same agency and were usually the same members of staff. Agency staff covered 113 molecular technologist shifts between July 2018 and September 2018.
- Agency clinical staff members were not granted a computer login and therefore were not expected to carry out any clerical tasks.
- The service had not used any bank staff to cover times of staff shortage between July 2018 and September 2018. However, if bank staff were required, prior to undertaking any shifts, they had to attend a local induction and have proof of completion of mandatory training relevant to the position they were required to fill, as well as previous equipment experience to establish suitability.
- At the time of inspection vacancies included two molecular imaging technologist/radiographer posts, one molecular imaging technologist and one imaging office administrator.
- The average sickness rate between July 2018 and September 2018 was 2% for molecular imaging radiographers and 3% for molecular imaging technologists.

Medical staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- The service did not directly employ any medical staff. There were 17 radiologists with practising privileges at the clinic. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. Their role was solely to report on scans and they did not see patients.
- Practising privileges for medical staff were approved by the chief executive officer in conjunction with the medical advisory committee and reviewed annually in accordance with the provider's practising privileges policy. Consultants with practising privileges had their appraisals and revalidation undertaken by their respective NHS trusts.
- PET CT consultant radiologists were onsite daily to report medical images and were available to provide medical advice. Consultants were also contactable by phone during operating hours. Consultants' mobile phone numbers were available to all staff members.

Records

- **Staff kept detailed records of patients' care and treatment.**
- Patients' individual care records were written and managed according to best practice.
- Records were accurate, complete, legible, up to date and stored securely. Records were electronic and available for access by staff.
- The radiology information system and picture archiving and communication system (PACS) used by the service was secure and password protected. Each staff member had their own personally identifiable password.
- All request forms and imaging related documentation were scanned into PACS. Medical images were transferred directly from the scanner workstation into PACS. Medical image reports were available on the radiology information system and PACS. Reports were available to the referring consultants on these systems and could also be shared via encrypted emails.

Medicines

- **The service followed best practice when prescribing, giving, recording and storing medicines.**
- The service followed best practice when prescribing, giving, recording and storing medicines. The provider's pharmacy team supported the PET CT service. Stock medication and the anaphylaxis kit were supplied by the provider's pharmacy.
- Quality assurance audits were completed as part of the provider's medicine management programme. PET CT imaging staff were responsible for medication safety and security, as well as medication storage, temperature monitoring and expiry date checks.
- Submitted data showed that on two occasions in March 2018 the temperature in the nuclear medicine injection cubicle drugs cabinet was above 25°C. This was

attributed to the air conditioning being turned off. The provider took advice from the in-house pharmacist, who advised that medicines were returned to the pharmacy for safe disposal.

- During inspection we saw a warning sign was placed on the air conditioning wall panel to ensure that temperature was always set at 20°C. The incident was discussed in a departmental staff meeting and agreed that drug cabinet temperatures were checked at the beginning and end of the working day. We evidenced these checks were completed on a record sheet and there were no gaps in recording for the three months prior to this inspection.
- The provider's in-house pharmacy carried out an audit of storage and security of medicines. This showed that storage and security was compliant in all areas, except flammable products which were not stored in a separate fire-proof cupboard. They were stored securely in a locked medicines cupboard but not completely segregated from other medications as per supplier's guidance. During inspection we saw that there was a fire-proof cupboard installed to address this.
- The service did not use any controlled medicines for any of their procedures and therefore did not have a controlled medicines policy in place.
- There were no non-medical prescribers in the service.
- We saw there were patient group directions in place for radiographers to administer certain drugs, including fluids for flushing of peripheral and central venous access devices. Patient group directions are written instructions to help with the supply and administration of medicines to patients, usually in planned circumstances.
- The provider told us there were arrangements in place for managing fluorodeoxyglucose (FDG) that protected patients from avoidable harm. Administration was in accordance with the provider's dispensing and administration of radiopharmaceuticals policy. We were unable to observe this procedure during inspection.

Incidents

- **The service managed patient safety incidents well.**
- There was an effective system in place for reporting incidents. Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses.
- There were no never events reported for the service from October 2017 to September 2018. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- There were no serious incidents reported for the service from October 2017 to September 2018. Serious incidents are events in health care where there is potential for learning or the consequences are so significant that they warrant using additional resources to mount a comprehensive response.
- Senior staff were aware of the requirements for reporting serious incidents to the CQC using the statutory notification route if this met the criteria, under Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.
- The service had recorded 15 incidents from January 2018 to December 2018 on their electronic incident recording system. Two incidents were graded as low harm, 13 were graded as no harm. Five incidents were classified as medical device or equipment and five were classified as clinical assessment. Two incidents were classified as clinical assessment and referred to extravasation. Extravasation is when a chemotherapy medication or other drug leaks outside the vein onto or into the skin, causing a reaction.
- The service looked for opportunities to learn lessons from these incidents. The electronic incident log recorded that written advice following administration of contrast was provided where the patient developed a skin rash and advice following extravasation was provided to the patient.
- Staff told us they completed an incident form for every adverse incident, clinical and non-clinical, accident or near miss. They said that all incidents were investigated and learning shared with staff at team meetings and in e-mail. We saw evidence of this shared learning recorded in team meeting minutes.
- There were effective arrangements in place in the event of a radiation or radioactive incident occurring such as radioactive spillage while carrying out a PET CT scan. Staff could tell us where the spill kits were located and we saw evidence that refresher spills training took place for all staff, which included a practical demonstration. One member of staff was not available for this training and we saw that they were subsequently booked to do this.

Good

Diagnostic imaging

- From March 2015, all independent healthcare providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- The service had a duty of candour policy in place. The policy defined when the principles of duty of candour should be followed. The Duty of Candour regulation was not applicable to any incident which occurred between October 2017 and September 2018.
- Staff were aware of the duty of candour regulation (to be open and honest) ensuring patients received a timely apology when there had been a defined notifiable safety incident.

.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We do not rate effective for this type of service.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness.**
- 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 National Institute for Health and Care Excellence (NICE), as well 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. Relevant and current evidence-based guidance, standards, best practice and legislation were identified and used to develop how services, care and treatment were delivered.
- 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 (IRR) and employer's procedures in place IR(ME)R) which protected staff and patients from ionising radiation. However, on the day of inspection, four members of staff we spoke with were unable to locate them.
- Dose reference levels (DRLs) were displayed in all operational areas, with a weight chart which gave guidance on correct dose administration for adults and children.
- Staff followed the provider's nuclear medicine policies and procedures. They noted the diagnostic reference level for each adult and paediatric investigation. Activity for each exposure was the optimised so it was the lowest practicable dose to the patient.
- The service audited their diagnostic reference levels for two CT examinations (brain and chest/abdomen/pelvis) between 2012 and 2018. The trend was shown to be generally downward except for a slight rise from 2017 to 2018. Staff concluded was due to changes in technique for optimal diagnostic yield.
- Overall results showed that current local DRLs fell below the recommended national DRL level and so demonstrated the practice of 'as low as reasonably practicable' (ALARP). We saw the new local DRL on display on the notice board in the PET CT control room.
- There was an active programme of local audits, including a pregnancy and breastfeeding audit completed in December 2018. This highlighted that standards were being met, but patient records did not fully reflect this. There was 100% compliance with recording pregnancy and breastfeeding status and recording of exclusion criteria.
- However, there was 80% compliance with recording the last menstrual period (LMP) date. This risk was mitigated since the exclusion criteria included a question about the patient's LMP, so the member of staff would be made aware of it but did not always write it down. The action plan also recorded that this would be re-audited within six months.
- Team meeting minutes we looked at confirmed that audit results were discussed and learning highlighted. We also saw that these results were presented to the provider's risk and governance committee as well as the patient experience, audit and guidelines committee.

- The service held regular discrepancy meetings in accordance with the Royal College of Radiologists (RCR) guidance. These monthly meetings were held as part of a collaboration between the provider and a local NHS hospital and discrepancies were presented as part of the wider hospital discrepancy meetings.
- Submission of discrepancies to these meetings meant there was independent peer review. They facilitated collective learning from radiology discrepancies and errors that enhanced patient safety. Learning points from these meetings were shared with staff and referrers as appropriate.
- All images were reviewed and separately reported by two radiologists and one of whom told us that findings were shared in an informal way.
- An audit of radiation protection arrangements was carried out at the service in November 2018 by the radiation protection adviser and found the service to be fully compliant with all regulatory requirements. The audit reviewed the service's departmental procedures, protocols and practices against the legislative requirements and associated guidance. Recommendations from the report for further improvement included:
  - Instant readout dosimeters should be used to determine typical body doses for the range of tasks associated with each clinical procedure.

  Following inspection, the provider confirmed that this action was in progress and due for completion in April 2019.

- It is recommended that employers of people working with radiation at Molecular Imaging are contacted to clarify arrangements for restriction of exposure and personal dosimetry.

  Following inspection, the provider confirmed that this action was in progress and due for completion in January 2019. Staff doses were monitored as required under the Ionising Radiation Regulations 2017 and audited every two months. Staff were required to record their radiation levels at the end of each working day. Any concerns about raised levels were discussed with the staff member and their safe practice with radioactive materials monitored.

- The staff training competency matrix should be checked against the Royal College of Radiologists guide to IRMER in Diagnostic Radiology.

  Following inspection, the provider confirmed that this action was in progress and due for completion in March 2019.

- The diagnostic reference levels policy should be reviewed to ensure the correct employer's procedures were being referenced.

  Following inspection, the provider confirmed that this action was in progress and due for completion in February 2019.

- The environment agency carried out an audit of the premises in December 2018. Recommendations from the report included:

- The provider should retain evidence that contamination monitoring training was refreshed at regular (to be determined by the user) intervals.
- The provider should add the Environment Agency hotline telephone number to their policy. A statement to be used by caller to indicate when the event involved radioactive material should also be added.
- During inspection we saw that refresher training took place and the policy was amended in accordance with Environment Agency recommendations.

Nutrition and hydration

- **The service had facilities to provide hot and cold drinks to patients.**
- There was a water fountain situated in the patient waiting area. Patients were provided with hot drinks and a biscuit following a procedure.
- We saw that patients who needed to fast before their scan were given information about this in advance.
- Fasting advice for diabetic patient was also highlighted and they were booked for an early appointment in the morning to ensure as far as possible that their blood sugar levels were stable.

Pain relief

- **Staff monitored patients to see if they were in pain during procedures.**
- PET CT is not a pain inducing procedure and no pain relieving medicine was held on site. In information sent to patients in advance, they were advised to continue their regular medications when attending for their scan.

Patient outcomes

Good

Diagnostic imaging

- **Managers monitored the effectiveness of care and treatment and used the findings to improve them.**
- Information about the outcomes of patients' care and treatment was routinely collected and monitored. The service undertook regular clinical audits internally within the organisation. They took appropriate action to monitor and review the quality of the service and to effectively plan for the implementation of changes and improvements required.
- Reporting guidelines and procedures were in place and there was an image quality feedback mechanism which monitored the quality of imaging procedures. This ensured images were of optimal diagnostic quality according to current best practice.
- The service worked collaboratively with colleagues to agree and deliver appropriate imaging pathways to ensure diagnosis within specified timescales, with minimised delays for patients. All images were reported in accordance with agreed local practice by competent staff to deliver accurate and effective radiological and clinical interpretation of images.
- Radiologists were allowed to report under a valid Professional Service Agreement. PET CT scans were peer reviewed through a dual reporting system.

Competent staff

- **The service made sure staff were competent for their roles.**
- Staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, took on new responsibilities and on a continual basis. 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.
- Staff had regular informal meetings with their manager and a performance appraisal annually to set goals to review them. At the time of inspection, all eligible staff had received an appraisal in the last 12 months.
- Appropriate training was provided to staff in the use of central and peripheral devices for administration of contrast and radiopharmaceuticals. We were told that in most cases, this eliminated the need for cannulation and gave patients a better experience.
- All eligible staff had had their professional registration checked in the last 12 months.
- All radiographers were registered with their professional body, the Health and Care Professions Council and met the standards to ensure delivery of safe and effective services to patients. Molecular imaging technologists were registered with the register of clinical technologists.
- Clinical staff were required to complete continued professional development (CPD) to meet their professional body requirements.
- In the event of any aspect of competency falling short of the required standard, the staff member's line manager was responsible for providing necessary support and guidance required to attain the relevant standard.
- Ongoing staff competence was managed through the performance review process, for example where local audit, complaints and incidents highlighted potential failing areas where different staff members may need support and development.
- We were assured staff working with radiation had appropriate training in the regulations, radiation risks, and use of radiation. Staff were aware of the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R17).
- We saw records which showed who was entitled to administer radioactive medicinal products (RMP).

Multidisciplinary working

- **Staff of different kinds worked together as a team to benefit patients.**
- Staff on site told us there was good multidisciplinary team (MDT) working with their colleagues. In addition, they consulted with their colleagues in other parts of the organisation. The lead radiologist attended the provider's paediatric oncology MDT held every two weeks.

Seven-day services

- PET CT was an elective care centre with no in-patient provision. It delivered a service five days a week between 8:30am to 6:30pm to cater for patient's needs. Patients would be seen on a Saturday if there was increased demand.
- Patients whose personal security or anonymity was at risk were seen out of hours on a Saturday morning.

Health promotion

- Information leaflets about what to expect and how to prepare for their PET CT scan were sent to patients with their appointment letters and were available in the waiting room.

Consent and Mental Capacity Act

- **Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.**
- Scan safety consent forms were completed by all patients prior to their scan, to record the patients' consent. These also contained patients' answers to safety screening questionnaires.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. Staff had received training on mental capacity.
- 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 and if they had concerns they would seek assurance from one of the doctors.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Compassionate care

- **Feedback from patients confirmed that staff treated them well and with kindness.**
- Staff understood and respected patient's personal, cultural, social and religious needs, and took these into account when allocating a member of staff to their care.
- Staff took the time, where possible, to interact with patient's and those close to them in a respectful and considerate manner. 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.
- Staff made sure that patients' privacy and dignity was respected. There were two changing areas, where patients could change their clothing and store them in a secure locker.
- We spoke with one patient who described the service as efficient and caring. They also told us, "I have been attending [the clinic] since 2015 and no matter how often I come, the staff are very careful to explain to me what to expect; they are all just so kind."
- Patients were provided with a patient feedback form. The feedback form allowed patients to provide any comments and ensure they had an opportunity to feedback on the service. We saw patient survey reports for January, April, June, August, October and December 2018. There was a total of 25 feedback forms received for these months. We were told that patients were more likely to fill in feedback forms at the beginning of their patient journey elsewhere in the organisation.
- All six survey reports recorded that 100% of patients would recommend the service to their family and friends. Four out of six respondents recorded 100% satisfaction with quality of care whilst two recorded 75% and 83% respectively citing lack of information about delay in appointment time.
- We reviewed patients' written comments which included, 'I was very nervous and anxious about the procedure, especially since I have difficult veins. [Member of staff] was so nice and reassuring; made me feel calm and confident. Another recorded, 'best injection technique ever' and '[member of staff] was very helpful and clear in everything they carried out.'
- There were signs around the clinic which highlighted the availability of chaperones. We were told how chaperones were often requested in advance. In instances where there was no prior request, staff told us they could usually accommodate this within the staff group; if not, then they would request one from another part of the organisation.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**

- Staff understood the impact that a patient's care, treatment or condition had on their wellbeing and on their relatives, both emotionally and socially. Staff were aware patients who attended the service were often feeling nervous and anxious. We saw how staff provided reassurance and support, demonstrating a calm and reassuring approach to an especially nervous patient.
- We were told that patients known to be nervous were often given a double appointment to offer assurance and show them how the scanning machines worked.
- People 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.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- Staff communicated with patients to ensure that they understood their care, treatment and condition. Staff took the time to explain the procedure and what would happen during their appointment.
- Staff recognised when patients and their relatives needed additional support to help them understand and be involved in their care and enable them to access this. This included, for example, access to language interpreters.
- Staff made sure that patients and their relatives could access further information or ask questions about their care and treatment. There was a range of leaflets available, such as information about the scans and information about common health conditions.
- Relatives or carers were permitted to remain with the patient for their appointment if this was necessary. Staff showed us how they ensured this person's safety from radiological exposure, including provision of a protective lead apron.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good.

Service delivery to meet the needs of people who used the service

- **The service planned and provided services in a way that met the needs of the people who used the service.**
- The facilities and premises were appropriate for the services that were planned and delivered. There was sufficient comfortable seating, toilets and a water fountain. There was sufficient space in each examination room for individuals accompanying the patient, such as relatives or carers, as well as patients.
- The PET CT clinic was recently refurbished in response to patient feedback. Attention was paid to secure patient changing area and lockers. Each examination room was assessed for suitability prior to its use and provided privacy and dignity.
- 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 building was serviced by a lift which enabled patients with reduced mobility to use the services on offer. This lift was large enough to accommodate a wheelchair or hospital bed.

Meeting people's individual needs

- **The service took account of patients' individual needs.**
- Patients' individual needs were accounted for. Staff delivered care in a way that took account of the needs of different patients on the grounds of age, disability, gender, race, religion or belief and sexual orientation.
- The service offered prostate specific membrane antigen (PSMA) for the treatment of advanced prostate cancer. Dependent upon which day the PSMA was received by the provider, Saturday clinics were held to ensure the antigen was used within 72 hours of delivery before it deteriorated.
- Patients who were claustrophobic or had a needle phobia were offered double appointments. This allowed staff time to show patients how the scanning machines worked and provide them with re-assurance.
- Patients who attended the service as part of their cancer pathway could access the provider's 'living well' programme as well as their Macmillian cancer centre.
- 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. We saw there was a dementia handbook available on the intranet. There was also a provider 'passport', which was a communication tool designed to help patients communicate their needs. We were told that this passport was not usually initiated by staff at the centre and was more likely to be already populated by other parts of the service.
- The service offered non-sedated PET CT scans to paediatric patients.
- A translation service was offered to all non-English speaking patients and there was 24-hour access to an Arabic speaking interpreter.
- Reasonable adjustments were made so disabled patients could access and use services on an equal basis to others. Patients appointment letters urged them to contact the unit if they had any needs, concerns or questions about their examination.

Access and flow

- **People could access the service when they needed it.**
- We saw that all referrer General Medical Council (GMC) registration numbers were checked to ensure a legitimate referral was made. The patient referral was then justified by a radiologist before an appointment was offered.
- The service did not operate a waiting list for appointments. Any patient referred to the service for a scan was booked for the next available appointment within 48 or 72 hours of their request, dependent on the type of procedure required. Urgent referrals were scheduled for next day appointments or referred to other PET CT services within the wider organisation.
- Once contacted, patients could choose an appointment time and date which was suitable and convenient to them. If it was not possible to accommodate the patient request, then the next available appointment was offered or availability within the provider's other PET CT centres was explored.
- The service did not offer same day stand by appointments due to scanning fasting requirements. Any cancellations were re-booked for a time convenient to the cancelled patient and those appointment times were released for additional patients to book if required.
- Patients who required both a fluorodeoxyglucose CT scan and a PET CT scan could have both carried out within the one appointment.
- Data submitted showed that 64% patients were seen either earlier than their appointment time or on time. Twenty- nine percent of patients were seen within 15 minutes, a further 5% in over 15 minutes and 2% of patients were late to their appointments.
- Molecular imaging technologists and radiographers provided support to the reporting radiologists to ensure images are reported on the same working day. When an investigation was not reported on the same working day, the molecular Imaging technologist or radiographer contacted the reporting consultant to ensure that the report was made available as soon as possible.
- An audit of reporting times on 1730 scans carried out between 01 July and 31 December 2018. The records were analysed for each type of examination and interval between examination and availability of the imaging report on PACS. This showed that 96% of scans were reported on the same day or within 48 hours.
- PET CT scans were peer reviewed through a radiologist dual reporting system. The provider told us where there was an urgent need for a report, these would be produced within a few hours on the same day. Consultants in multidisciplinary teams across other parts of the provider's service could view the same images in a fast-digital way.
- Between July and December 2018, 1730 records were audited for each type of examination and interval between examination and availability of the imaging report on the picture archiving and communication system. It was company policy to turn around inpatient reports within 24 hours and outpatient reports within 48 hours.
- The audit showed that between 94% and 100% of all reports were turned around in 48 hours. The audit also noted that 1% of all PET CT scans and 4% of all diagnostic CT scans were not available on the picture archiving and communication system within 48 hours. The action plan set out a re-audit plan, as well as sharing the results with clinical and technical staff.
- There were 32 cancelled procedures between October 2017 and September 2018. Thirteen of these were due to machine breakdown or other equipment failure and 19 were due to radiopharmaceutical production failure.
- The provider told us each patient affected was offered an appointment at another site and support to travel there if they wished. If they did not take this alternative,

they were offered an on-site appointment within 24 hours. In all cases, patients were risk assessed by a doctor to ensure the delay did not have a detrimental effect on their health.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**
- Complaints were managed centrally by the Harley Street Clinic in accordance with the provider's complaints procedure and were responded to promptly to ensure swift resolution. All complaints were reviewed monthly at the governance meeting and at staff departmental meeting to ensure sharing of learning.
- There were four formal complaints between September 2017 and September 2018 which went through the formal complaints process and all were upheld. One of these related to extravasation during a diagnostic CT scan. Extravasation is when a chemotherapy medication or other drug leaks outside the vein onto or into the skin, causing a reaction. In addition, there were two informal complaints during this same period, both of which were rapidly resolved. We saw learning from these complaints was shared at subsequent staff meetings.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good.

Leadership

- **Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.**
- The leadership team had invested in key individuals to ensure the executive team was suitably competent and experienced.
- PET CT at The Harley Street Clinic was part of the wider HCA Healthcare UK group and was led by a substantive chief executive officer who was the registered manager. They were supported by a head of governance, deputy chief executive and a medical director.
- The day-to-day leadership team consisted of a head of imaging services and projects and a deputy molecular imaging manager.
- Members of the executive team we spoke with were pragmatic about potential challenges to quality and sustainability, including the growth of competition in the market place. They said that the service provided must be of such a consistently high standard that patients would continue to choose the service.
- Most staff we spoke with told us how leaders were visible and approachable. They said they were comfortable to approach any member of the leadership team to confirm information or to seek support.

Vision and strategy

- **The service had a vision for what it wanted to achieve and workable plans to turn it into action.**
- The provider had a clear vision and a set of values, with exceptional care by exceptional staff as their top priority. The chief executive officer described how as an organisation, they had a responsibility to continue to grow the services they provided. Some of the ways in which this was realised was through investment in their employees and infrastructure.
- The service values were:

- Recognising and valuing everyone as unique and individual
- Treating people with compassion and kindness
- Acting with absolute honesty, integrity and fairness
- Trusting and treating one another as valued members of the HCA family with loyalty, respect and dignity

Culture

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- There was 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. 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 provider had a whistle blowing policy and duty of candour policy which supported staff to be open and honest.

Governance

- **The service systematically improved service quality and safeguarded high standards of care by creating an environment for good clinical care to flourish.**
- There were robust governance frameworks to support the delivery of good quality care. These came under the general governance of The Harley Street Clinic.
- 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 comprehensive standing agenda, which included training, infection prevention and control, performance, policies and procedures. It also included workflow, risks, complaints, incidents and audits.
- The manager ensured team meeting minutes were shared with all staff through email. We saw staff signed team meeting minutes when they read them, including those who could not attend on the day. Minutes referred to any actions from the previous meeting.
- Feedback and actions from performance discussion of local incidents were fed into processes at a corporate level. We saw evidence of this process in meeting minutes and meeting notes during our inspection.
- 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.
- All reporting consultants granted practising privileges at PET CT were approved by the chief executive officer in conjunction with the medical advisory committee and reviewed annually in accordance with the provider's practising privileges policy.
- Consultants were required to provide evidence of their NHS appraisal summary in an electronic template. The process ensured all doctors had sufficient indemnity insurance and that individuals acted within their defined scope of practice.
- The medical advisory committee considered all new applications; reviewed any individual subject to GMC license restrictions; and provided support to the chief executive and medical director where concerns over clinical conduct or practice had been raised.
- PET CT submitted exception reports to the quarterly Radiation Protection Committee meetings attended by the head of imaging. Any arising actions from the committee were then actioned by the service manager.
- Procedures for information governance and clinical records management followed best practice. The provider had data sharing agreements in place with all image exchange portal (IEP) recipients.

Managing risks, issues and performance

- **The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- There was a risk assessment system in place locally with a process of escalation to the governance and risk committee and the corporate risk register. The local risk register was reviewed and updated each month at the clinical governance meeting.
- The local risk register included risks to patients and staff from medicines and equipment used, supply of medicines and staffing levels. The register also included timescales and accountability. Information from the risk register was shared at monthly staff meetings and staff we spoke with could tell us about some of them.
- There were 13 risks on the departmental risk register, six of which were graded 'medium' and seven 'low'. Medium risks included administration of intravenous (IV) Contrast; loss of external products or radiopharmaceutical supplies; staffing shortages; and loss of power and utilities.
- The radiation protection committee met four times each year and was chaired by the head of imaging services.
- The service did not have a back-up generator. However, there were measures to ensure equipment was functional. There was an emergency pager system in place to guarantee contact was maintained with other parts of the service if there was a loss of utilities. In the event of an electrical failure, patients awaiting scans would be re-directed to other HCA UK sites to have their appointments re-booked and scans completed.

Managing information

Good

Diagnostic imaging

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- The provider used a secure image sharing portal for exchanging images with consultants and NHS trusts. Images which were provided to patients or consultants on discs were encrypted and a unique password provided for each user.
- Testing of security systems was done regularly through the central IT and securities team to assess the vulnerability of systems and ensure a high level of security.
- The service was aware of the requirements of managing a patient's personal information in accordance with relevant legislation and regulations. General Data Protection Regulations (GDPR) had been reviewed to ensure the service was operating within the regulations. Staff viewed breaches of patient personal information as a serious incident and would therefore manage this as such and escalate to the appropriate bodies.
- There was a corporate data protection officer (DPO) and team who received automated notifications about data breaches. They offered advice and if necessary, carried out an investigation. The DPO advised on whether the incident was reportable to the information commissioner'sOffice (ICO) and was responsible for reporting any breaches within 72 hours of the breach being known. Since GDPR came into operation in May 2018, there were no breaches reported to the ICO.
- Electronic patient records were kept secure to prevent unauthorised access to data. However, authorised staff demonstrated they could be easily accessed when required.
- There was an information governance sub-committee group which was accountable to the governance and risk committee, and ultimately the quality and safety review group. There were processes for ensuring notifiable incidents were reported to relevant external agencies, including the CQC and the Health and Safety Executive.

Engagement

- **The service engaged well with patients and staff to plan and manage appropriate services, and collaborated with partner organisations effectively.**
- 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. We were told that the recent environmental refurbishment was in response to patient feedback.
- We were told that staff surveys informed trends and action plans were developed to improve staff engagement.

Learning, continuous improvement and innovation

- **The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.**
- The service had a digital scanner, which improved small lesion detectability and reduced CT dose without compromising the image quality and produced faster scans.
- There was a radioisotope patient automatic dose dispenser which minimised staff radiation exposure.
- The service offered prostate-specific membrane antigen (PSMA) for the treatment of advanced prostate cancer, also known as metastatic prostate cancer.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all staff are easily able to access the Ionising Radiation (Medical Exposure) Regulations 2017 Employers Procedures so that they fully understand their individual roles and responsibilities in procedures.