

The Nottingham InHealth Specialist Imaging Centre (NISIC)

Quality Report

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

Ratings

Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Not sufficient evidence to rate 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

Summary of findings

Letter from the Chief Inspector of Hospitals

The Nottingham InHealth Specialist Imaging Centre (NISIC) is operated by InHealth. The service provides PET-CT (positron emission tomography-computed tomography) and diagnostic facilities for adults and children.

We inspected PET-CT diagnostic facilities for adults and children.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced inspection on 22 October 2018.

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

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

The main service provided by this unit was PET-CT.

Services we rate

We rated this service as good.

We found good practice in relation to diagnostic imaging:

- There were effective systems in place to keep people protected from avoidable harm.
- There were sufficient numbers of staff with the necessary skills, experience and qualifications to meet patients' needs.
- There was a programme of mandatory training in key safety areas, which all staff completed, and systems for checking staff competencies.
- Equipment was maintained and serviced appropriately and the environment was visibly clean.
- Staff were trained and understood what to do if a safeguarding issue was identified.
- Records were up to date and complete and kept protected from unauthorised access.
- Incidents were reported, investigated and learning was implemented.
- The service used evidence based processes and best practice, this followed recognised protocols. Scans were timely, effective and reported on in timely way.
- Staff were competent in their field and kept up to date with their professional practice.
- The service worked well with internal and external colleagues and partnership working was strong.
- Staff demonstrated a kind and caring approach to their patients, supported their emotional needs and provided reassurance.
- Appointments were available at short notice if required.
- The referral to scan times and scan to reporting times were appropriate and well within expected ranges.
- The service had few complaints but acted upon feedback from patients and staff.

Summary of findings

- The service had supportive, competent managers who led by example. Staff understood and were invested in the vision and values of the organisation. The culture was positive and staff demonstrated pride in the work and the service provided.
- Risks were identified, assessed and mitigated. Performance was monitored and data used to seek improvements for both staff and patients.
- Engagement with staff, stakeholders and partners was a strong feature of the service.

However, we also found the following issues that the service provider needs to improve:

- Medicines were not always managed in line with best practice. For example, medicine fridge temperatures were not monitored.
- Personal protective equipment was not always used as per InHealth policy and best practice. As a result, we were not assured that patients were protected from risk of cross infection.
- InHealth uniform policy was not always followed as staff were wearing unauthorised jewellery. As a result, we were not assured that patients were protected from a risk of cross infection.


Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve.

Amanda Stanford

Deputy Chief Inspector of Hospitals (Central)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	Diagnostics was the only activity the service provided. We rated this service as good because it was safe, caring, responsive and well-led. We do not rate the key question of effective.

Summary of findings

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Good 

The Nottingham InHealth Specialist Imaging Centre (NISIC)

Services we looked at

Diagnostic imaging

Summary of this inspection

Background to The Nottingham InHealth Specialist Imaging Centre (NISIC)

InHealth was established over 25 years ago with the aim of reducing waiting times, speeding up diagnoses, saving money and improving patient pathways. The Nottingham centre opened in 2006 following a local trust led procurement exercise. The NHS trust hold the contract with NHS England for the service and InHealth are the nominated sub-contractor for the PET-CT service. The building was designed specifically for the scanning of PET-CT patients and is leased from the trust. Both private and NHS referrals are received from consultants at local NHS hospitals. Although the service is independently run

by InHealth, support services are provided from the trust including Administration of Radioactive Substances Advisory Committee (ARSAC) licence holders, medical physics staff for equipment testing, radiation protection services and medical physics expert (MPE) services for PET-CT. Additionally image reporting is performed by trust employed radiologists.

A registered manager had been in post since March 2011. We inspected this service on 22 October 2018. This was the first inspection since registration.

Our inspection team

The team inspecting the service comprised a CQC lead inspector, one CQC assistant inspector, and a specialist advisor with expertise in radiological services. The inspection team was overseen by Simon Brown, Inspection Manager.

Information about The Nottingham InHealth Specialist Imaging Centre (NISIC)

The PET-CT unit at The Nottingham InHealth Specialist Imaging Centre (NISIC) is a positron emission tomography-computed tomography service which undertakes scans on patients to diagnose disease, disorder and injury. The service has a fixed scanner and is located within the grounds of a local NHS trust. All staff are employed by InHealth. The unit is operational Monday to Friday, 8am to 5pm, Saturdays on an adhoc basis to assist with waiting lists if required. Both inpatients and outpatients are scanned in this service. There are no facilities for clinical emergency patients.

The premises are leased from the trust and managed by InHealth; the PET-CT scanner and equipment belong to InHealth.

The building was designed specifically for the scanning of PET-CT patients; the building itself is leased from the trust. The building consists of four patient rooms, a 'hot'

toilet (a toilet used after injection of a radiopharmaceutical), dispensing lab, radioactive waste cupboard and equipment room. The building has its own access and uses pay and display hospital car parking.

Ground floor consists of reception/waiting area, visitor toilets, plus: 'Controlled Radiation Areas' - PET/CT scanner room, four patient uptake rooms, radioisotope dispensing room, patient radioactive toilet and radioactive waste store cupboard.

'Supervised Radiation Areas' - PET-CT scanner control room and patient changing cubicle.

The MRI area (which is managed by a separate on-site unit manager) - MRI scanner room, scanner control room, patient changing rooms, patient preparation area and a cleaners' store cupboard.

The first floor consists of a plant room, training/conference room, two reporting rooms, kitchen/staff room, five offices, staff toilets.

Summary of this inspection

During the inspection, we visited the PET-CT scanning room, control room, patient preparation area, patient changing room and patient waiting area. We spoke with five staff including three radiographers and two radiographic assistants. We spoke with five patients. During our inspection, we reviewed four electronic records.

There was one completed investigation of the service by the CQC during the 12 months before this inspection, this related to a specific incident. No regulatory action was taken against the service.

Activity (July 2017 to June 2018)

- The service undertook 3696 scans during the year, this equates to 3696 patients.

The service employed two radiographers, one imaging services manager who was the registered manager, two radiographic assistants and two patient administrators.

Track record on safety;

- Zero Never events
- Clinical incidents seven insignificant (low)harm, 14 minor, one moderate harm, no severe harm, no death
- No serious injuries
- No incidence of healthcare acquired Meticillin-resistant Staphylococcus aureus (MRSA).

- No incidence of healthcare acquired Meticillin-sensitive staphylococcus aureus (MSSA).
- No incidence of healthcare acquired Clostridium difficile (c. difficile).
- No incidence of healthcare acquired Escherichia coli (E-Coli).
- Seven complaints.

Services accredited by a national body:

- International Organization for Standardization - information security management systems - ISO 27001 2013 - August 2013 to December 2019
- ISO 9001: 2015 – December 2001 to December 2019
- Investors in People Gold award - December 2016 to December 2019.

Services provided at the service subcontracted by the NHS trust:

- Use and maintenance of premises.
- Use of hospital facilities.
- Grounds maintenance.
- Clinical and or non-clinical waste removal.
- Maintenance of non- PET-CT medical equipment.
- Maintenance of PET-CT medical equipment.
- Medical provision (in the event of emergency).

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?

We rated safe as 'Good' because:

- There was an open incident reporting culture within the unit, and an embedded process for staff to learn from incidents.
- All staff demonstrated an understanding of the duty of candour and the principles behind this.
- Staff were knowledgeable about safeguarding processes and what constituted abuse.
- There were sufficient numbers of staff with the necessary skills, experience and qualifications to meet patients' needs. They were supported by a programme of mandatory training in key safety areas.
- Staff working with radiation were provided with appropriate training in the regulations, radiation risks, and use of radiation.
- Equipment was serviced and visibly clean and processes were in place to ensure all items were well maintained.
- The environment was fit for purpose.

However;

- Medicines were not always managed in line with best practice. For example, medicine fridge temperatures were not monitored.
- Personal protective equipment was not always used as per InHealth policy and best practice. As a result, we were not assured that patients were protected from risk of cross infection.
- InHealth uniform policy was not always followed as staff were wearing unauthorised jewellery. As a result, we were not assured that patients were protected from a risk of cross infection.
- Action plans were provided post inspection to address these concerns.

Good



Are services effective?

We don't currently rate effective

- Policies, procedures and guidelines were up to date and based on National Institute for Health and Care Excellence (NICE) guidelines, relevant regulations and legislation.
- Staff worked collaboratively as part of a multi-professional team to meet patients' needs.

Not sufficient evidence to rate



Summary of this inspection

- There were systems to show whether staff were competent to undertake their jobs and to develop their skills or to manage under-performance.
- There was effective multidisciplinary team working throughout the unit and with other providers.
- Staff had regular development meetings with their unit manager, and were encouraged to develop their roles further.
- Information provided by the hospital showed 100% of staff had been appraised.
- Staff demonstrated an effective knowledge of the consent process and we observed staff gaining consent in accordance with local policy and professional standards.

Are services caring?

We rated caring as 'Good' because:

- Patients were always treated with dignity, respect and compassion. This was reflected in the feedback received from patients who told us staff were very helpful.
- Patients received information in a way which they understood and felt involved in their care. Patients were always given the opportunity to ask staff questions, and patients felt comfortable doing so.
- Staff provided patients and those close to them with emotional support; all staff were sympathetic to anxious or distressed patients

Good



Are services responsive?

We rated responsive as 'Good' because:

- The service was planned with the needs of service users and partner organisations in mind.
- There was a proactive approach to meeting the individual needs of patients. Staff in the unit had worked hard to ensure the needs of patients living with dementia were taken into consideration.
- Staff were encouraged to resolve complaints and concerns locally, which was reflected in the low numbers of formal complaints made against the service.
- Patient complaints and concerns were managed according to InHealth policy. Complainants were kept informed of the progress.
- Complaints were investigated thoroughly. We saw learning identified and shared to improve service quality.

Good



Summary of this inspection

- Services were planned and delivered in a way that met the needs of the local population. On the day appointments could be provided for patients with the required referral paperwork, as well as a range of appointment times for those who worked during the week.
- Patients could access services easily; appointments were flexible and waiting times short. Appointments and procedures occurred on time and patients were kept informed of next steps throughout the care pathway.

Are services well-led?

We rated well-led as 'Good' because:

- The unit had a clear vision and values which were realistic and reflected through team and individual staff member objectives.
- There was a clear governance structure, which all members of staff were aware of. There was evidence of information escalated from local level governance meetings and information cascaded from top-level governance meetings.
- Staff were extremely positive about their local leaders and felt they were supported and appreciated.
- The unit had its own risk register and managers had clear visibility of their own risks and were knowledgeable about the mitigating actions taken.
- Up to date policies and procedures were in place to support staff in the delivery of safe and effective care.
- There was a culture of openness and honesty supported by a whistle blowing policy and freedom to speak up guardian.
- Managers were open to innovative ideas. Plans were in discussion to increase patient numbers and ensure sustainability.

Good








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

Diagnostic imaging

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

Are diagnostic imaging services safe?

Good 

Mandatory training

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Annual mandatory training courses were delivered as part of refresher training and development and included 'face to face' and 'e-learning' modules. Staff training files included a contemporaneous training record. This included details of training undertaken including; fire safety and evacuation, health and safety for healthcare, equality and diversity, infection prevention and control, moving and handling objects and people/patients, safeguarding adults, safeguarding children level 2, customer care and complaints, basic life support (BLS) and data security awareness.
- At the time of this inspection, all staff had completed their mandatory training.

Safeguarding

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The lead for safeguarding was the nominated individual who was trained to level four.

- Staff were trained to recognise adults at risk and were supported with an effective safeguarding adults' policy in place. Staff we spoke with demonstrated they understood their responsibilities and adhered to safeguarding policies and procedures.
- At the time of this inspection all staff had received safeguarding adults training.
- The unit usually held a paediatric list once a week. All staff had received training in safeguarding children and young people level two. During any paediatric scanning list, a registered children's nurse was always present along with a consultant trained at level three. This met intercollegiate guidance: Safeguarding Children and Young People: Roles and competencies for Health Care Staff (March 2014).
- We saw contact numbers for all local adult and child safeguarding referrals were located in the PET-CT observation room.

Cleanliness, infection control and hygiene

- The service mostly controlled infection risk. Staff kept themselves, equipment and the premises clean. However, they did not always use control measures to prevent the spread of infection.
- InHealth Limited had infection prevention and control (IPC) policies and procedures in place which provided staff with guidance on appropriate IPC practice in for example, communicable diseases and isolation.
- During this inspection we observed all areas of the service to be visibly clean. There was a service level agreement for cleaning the unit. This was done daily in the mornings to ensure staff safety when radiation levels were at their lowest.

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- Staff cleaned medical devices, between each patient and at the end of each day. These followed manufacturer's and IPC guidance for routine disinfection. We observed staff cleaning equipment and machines during this inspection. We reviewed all machines in use during this inspection, and saw where appropriate disinfection of the machines had taken place.
- All the patients we spoke with were positive about the cleanliness of the unit and the actions of the staff with regards to infection prevention and control. Patients told us, "the department is very clean". We observed all staff washing their hands and using hand gel when appropriate.
- Between July 2017 and June 2018 there were no incidences of health care acquired infection in the unit.
- Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO) '5 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. Results for the reporting period July 2017 to June 2018 showed a compliance rate of 100%. Hand hygiene results were communicated to staff through their staff meetings and through email.
- Throughout the unit all staff were observed to be compliant with best practice regarding hand hygiene, and staff were noted to be bare below the elbow. However, staff were seen wearing jewellery, for example necklaces, which we were told by managers was contrary to InHealth uniform policy.
- As this was highlighted in our post inspection feedback we were provided with an action plan which identified ; Following our inspection all staff were reminded about the need to follow InHealth uniform policy.
- There was access to hand washing facilities and a supply of personal protective equipment (PPE), which included gloves and aprons. During this inspection we observed all staff to be using gloves appropriately. However, aprons were not worn during patient contact, cannula insertion or injection of intravenous saline. We were told "we just don't wear aprons we never have". We reviewed InHealth policy which stated the use of aprons was required during clinical patient activity in order to reduce the risks of cross contamination.
- We witnessed staff mostly adhering to NICE QS61 Statement 5, (People who need a vascular access device have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the device and its removal). Staff were trained in cannulation and explained to us the need to monitor cannula sites for extravasation. We witnessed staff explain the procedure to the patient and removed the cannula promptly post scan and disposed of it correctly in a contaminated sharps container. However, as aprons were not worn for this procedure we were not assured the guideline was adhered to completely.
- As this was highlighted in our post inspection feedback we were provided with an action plan which identified ; All staff were advised to follow InHealth policy and use of aprons would now form part of the regular infection prevention audits
- Waste was handled and disposed of in a way that kept people protected from avoidable harm. Staff used the correct system to handle and sort different types of waste and these were labelled appropriately.
- All radioactive waste was stored in a designated locked room with removal dates of seven days in advance to ensure safe removal by the waste collection company.

Environment and equipment

- The service had suitable premises and equipment and looked after them well.
- The layout of the unit complied with health and building notification (HBN06) guidance. Access was good, parking was pay and display with a secure entry point to the unit. However, we were told patients often complained about the lack of parking and the difficulty in finding the building. InHealth staff send full instructions with each appointment explaining where the building is and about the parking.
- A reception area, outside of the scanning area, was available providing magazines, refreshments and

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toilet facilities for patients and relatives. A scanning observation area allowed visibility of all patients during scanning. We observed there was sufficient space around the scanner for staff to move and for scans to be carried out safely. During scanning all patients had access to an emergency call buzzer. Music could be played and a microphone allowed contact between the radiographer and the patient at all times.

- Closed circuit television (CCTV) was installed in patient clinical areas to monitor patients post radiopharmaceutical administration. Signs were displayed warning of CCTV in progress. We also observed staff explain to the patients the reasons for CCTV in the area.
- There was a system in place to ensure that repairs to equipment were carried out if machines and other equipment broke down and that repairs were completed quickly so that patients did not experience delays to treatment. Servicing and maintenance of premises and equipment was carried out using a planned preventative maintenance programme. During our inspection we checked the service dates for all equipment, all equipment was within their service date. The generators were also tested monthly on a planned schedule to ensure patient scanning was not affected.
- The unit was located in the grounds of an NHS hospital. A service level agreement was in place with the hospital for the day to day maintenance of all equipment and the environment. Failures in equipment and medical devices were reported through the hospital technical support team. Staff told us there were usually no problems or delays in getting repairs completed. All equipment conformed to the relevant safety standards and was regularly serviced. All electrical equipment met the Health and Safety Executive standard 2013 of combined inspection and test.
- The service has a risk assessment for all new or modified use of radiation. The risk assessments addressed occupational safety as well as considering risks to people who use services and public. For example, cleaning staff were only allowed into the area when the radioactivity of the areas to be cleaned was at a safe level. Windows in the treatment room

were also set at a height that reduced the risk of radioactive spread out of the building affecting any passers-by or gardeners maintaining the area outside. All doors and walls were also lead lined.

- All patients were given a leaflet post scan explaining the time that they will remain 'slightly radioactive' advising against close contact with babies, children and pregnant women.
- Staff were also monitored for exposure with the use of detectors and rings which were sent off monthly. All staff were aware of the importance of being aware of their own exposure.
- We saw radiation warning signs and lights were correctly located outside all clinical diagnostic imaging areas. Access to these areas was restricted to staff and escorted patients and relatives only. Visitors for example maintenance staff had to be given authorisation by a senior member of the team and were required to sign a document of understanding. During our inspection we were also required to complete the access documents for authorisation to the controlled area.
- We saw quarterly service records for the scanner which included downtime and handover time.
- Patient weighing scales were available in the unit and we saw where they had been appropriately service tested. Staff told us, in the event the weighing scales developed a fault or were unfit for use, a replacement set was available and the fault would be reported.
- We checked the resuscitation equipment. The resuscitation equipment appeared visibly clean. Single-use items were sealed and in date and emergency equipment had been serviced. Records indicated resuscitation equipment had been checked daily by staff and was safe and ready for use in an emergency. The service had access to the emergency resuscitation team based in the host hospital who would attend in the event of an emergency. The service could telephone an emergency number and this would facilitate emergency bleep holders in the hospital to respond immediately.

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- Emergency pull cords were available in areas where patients were left alone, such as toilets and changing areas. Call bells were available within the scanner which patients could press if they wanted the scan to stop.
- Resuscitation equipment was available outside of the scan room. The scanner had a removable trolley. The staff we spoke with explained the procedure for removal of a patient from the scanner. As the scan room provided enough space any resuscitation could take place without moving the patient any further.
- There were procedures in place for removal of a collapsed patient. However, we were told evacuation procedures were discussed at team meetings but not practised. Staff told us they had not removed a patient in an emergency for a cardiac arrest.
- Chemical products deemed as hazardous to health were in locked cupboards or rooms that were only accessible to authorised staff.
- Spills kits, for the safe removal of radiation spillage and bodily fluids were readily available in the clinical area we visited.

Assessing and responding to patient risk

- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- Radiation risks to patients were managed in line with guidance from the International Atomic Energy Agency (IAEA) Applying Radiation Safety Standards in diagnostic radiology and interventional procedures using x-rays. The Committee on Medical Aspects of Radiation in the Environment (COMARE 16th report): Review of radiation dose issues from the use of CT published 14 August 2014.
- We saw local rules (IRR) and employer's procedures (IR(ME)R) which protect staff and patients from ionising radiation. All staff had signed to accept these rules and provide evidence that they had read them.
- The service ensured that women (including patients and staff) who were or may be pregnant always inform a member of staff before they were exposed to any radiation in accordance with IR(ME)R. In the case when it was necessary to administer radioactive substances

to a female of childbearing potential, the radiation exposure was administered at the minimum consistent with achieving the desired clinical information.

- The radiation protection advisor (RPA) and the medical physics expert (MPE) were located in the onsite trust building and were easily accessible for providing radiation advice. The RPA had visited the unit the week before our inspection for a yearly planned review. A report had not yet been finalised. The 2017 inspection had been reported at the RPA meeting and all actions completed.
- The service had appointed radiation protection supervisors in the clinical area. Information was displayed informing staff and patients/relatives who this was.
- There were signs and information in the radiation waiting area informing people about areas or rooms where radiation exposure took place.
- Staff assessed patient risk and developed risk management plans in line with national guidance. For example, we saw evidence of a PET-CT patient safety questionnaire. Risks were managed positively and updated appropriately where a change in the patient's condition had arisen for example managing the claustrophobic patient.
- Patients had the choice of wearing their own clothes or changing into a gown prior to the scan. All patients we saw wore their own clothes.
- There were clear pathways and processes for staff to assess patients using services in radiology departments who are clinically unwell and need hospital admission. For example, the InHealth routine guidance policy was available to guide staff in referring patients to an emergency department for conditions related to the brain and spine. Patients that became unwell in the unit would be initially reviewed on site if necessary then referred to their GP. Staff told us that if the patient required more urgent treatment they would call 999.
- The service ensured that the 'requesting' of an PET-CT was only made by staff in accordance with the Ionising Radiation Medical Exposure Regulation (IR(ME)R) guidelines. All referrals were made using dedicated

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referral forms which were specific to the contract with the commissioning group. For example, the local referring hospital used a specific referral form designed for them. All referrals would be either received from them or InHealth referral desk for private scans.

- All referral forms included patient identification, contact details, clinical history and examination requested, and details of the referring clinician/practitioner. Information regarding the correct radiopharmaceutical for each scan was also recorded.
- All children seen in the unit were on a dedicated paediatric inpatient list (once a week), which included a consultant radiologist and a Registered Children's Nurse both Paediatric Immediate life support trained (PILS) and safeguarding level three. All radiographers within the unit were also Immediate life support trained as a local requirement. This was part of InHealth's specific paediatric protocol.
- We were told about and shown the pathway for unexpected urgent clinical findings. In the case of NHS patients, an urgent report request was sent to the reporting provider. Once the report was received (within 24 hours), an email was sent to the agreed staff within the referring trust to highlight an urgent report. In addition to this, InHealth's picture archiving and communications system (PACS) team also contacted the referrer by phone to inform them an urgent report had been sent and the person who was spoken to within the trust was recorded on the database. They were asked to verbally acknowledge that an email with the report had been received. If the patient was a private patient, the reporting radiologist was contacted by a member of staff to advise them of the urgent report to ensure it received prompt attention. If at time of scan, the radiographers thought the patient needed urgent medical attention, the patient was advised to attend accident and emergency (A&E). All images would be sent to the trust urgently via the image exchange portal to assist in patient management.
- There were processes to ensure the right person got the right radiological scan at the right time.
- We also witnessed the staff using The Society of Radiographers (SoR) "Paused and Checked" system. Referrer error was identified as one of the main causes

of incidents in diagnostic radiology, attributed to 24.2% of the incidents reported to the CQC in 2014. The six-point check had been recommended to help combat these errors. Pause and Check consisted of the three-point demographic 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.

- We saw the Society of Radiographers (SoR) poster within the unit reminding staff to carry out these checks.
- A review was carried out at the location to assess compliance with the (IRR17) and the (IR(ME)R17) in May 2018. Overall good compliance was seen with IRR17 and IR(ME)R. The Imaging Services Manager and radiology staff were aware of the local rules and procedures and these documents were reviewed on a regular basis. Most of the recommendations following this audit related to updating the current documentation to comply with the implementation of the new IRR17 and IR(ME)R regulations. Some minor changes to the procedures were recommended to reflect local arrangements.
- Staff were provided with a debrief, or other support after involvement in any incident/accidents.

Radiography 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.
- An InHealth staffing policy was in place, this enabled the unit to effectively maintain safe staffing levels and ensured there were sufficient numbers of suitably qualified, skilled staff to carry out daily tasks. The policy and procedure outlined how the headcount (actual number of staff on duty) and full time equivalent (FTE) numbers were to be calculated and managed at unit level.
- Staff in the unit consisted of one imaging services manager, two FTE radiographers, two radiography assistants and 1.8 FTE patient administrators.
- The unit manager was trained in rostering and used the headcount guidance tool to support with

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maintaining safe numbers. Business continuity plans were in place to guide the unit manager when responding to changing circumstances. For example, sickness, absenteeism and workforce changes. Agency staff were rarely used only two shifts in the reporting period July 2017 to June 2018.

- The unit manager could use regular radiographer cover from the mobile units to cover days off and leave if required. This ensured staff continuity and familiarity with the unit.
- All staff we spoke with felt that staffing was managed appropriately. At all times there were at least two staff in the unit. This included one radiographer.
- During our inspection we were told the unit manager was leaving for career progression. Early recruitment was planned to allow for overlap of old and new staff and an uplift of a staff member to facilitate extra training and induction.
- Radiographers told us they could contact a radiologist at the referring site for advice at any time.
- Radioisotope administration was carried out at this site we saw protocols were in place and staff were trained to recognise and treat reactions, including anaphylaxis. However, this had never been necessary in the unit.

Medical staffing

- The service did not employ any medical staff, however they had access to a radiologist from the trust at all times who was present on site and available to attend if required.

Records

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- Staff kept and updated individual patient care records in a way that protected patients from avoidable harm. Records were electronic and available for access by staff.

- Patients completed a consent checklist form which recorded the patients' consent and answers to the safety screening questions. This was later scanned onto the electronic system and kept with the patients' electronic records.
- Patients personal data and information were kept secure and only staff had access to that information. Staff received training on information governance and records management as part of their mandatory training programme.
- Staff completing the scan updated the electronic records and submitted the scan images for reporting by the relevant organisation. They had two systems which they could switch between depending on the referral organisation.
- The quality of images was peer reviewed locally and quality assured on a corporate level. Any deficiencies in images were highlighted to the member of staff for their learning. However, this was very rare and the services re-scanning rate was negligible.
- We reviewed four patient care records during this inspection and saw records were accurate, complete, legible and up to date. Paper records were shredded as per policy once the information was uploaded.
- The service provided electronic access to diagnostic results to the referring hospital and could share information electronically if referring to an A and E for emergency review.
- We saw the Radiology Information System and Picture Archiving and Communication System was secure and password protected. Each staff member had their own personally identifiable password.

Medicines

- The service followed best practice when prescribing, giving and recording but not always storing medicines. Patients received the right medication at the right dose at the right time.
- Emergency drugs were available at all times in accordance with the InHealth Resuscitation policy and local policies and procedures. Emergency drugs were checked daily and the person making the check signed and dated that the check had been carried out.

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- InHealth policy stated, 'emergency drugs will be kept in a sealed box; if a box has been tampered with or the seal is broken, a new box will be requested urgently from the hospital or supplying pharmacy'. However, a large plastic medicines box was stored on top of the arrest trolley with no tamper evident seal. Staff we spoke with had been advised by the trust resuscitation team that this box needed to remain accessible on the trolley. During our inspection staff were discussing with the trust use of a tamper evident seal to reduce the risk of unauthorised access and reviewing the necessity of all the medicines stored for resuscitation.
 - An action plan was received post inspection which highlighted that the storage of emergency medicines was under review with the trust.
 - Emergency medicines were available in the event of an anaphylactic reaction.
 - Medicines required to be stored at a temperature of between two and eight degrees centigrade were stored in a dedicated medicines refrigerator. However, the refrigerator was not monitored by staff and recordings of temperature were not available. The refrigerator had ice inside on checking and the highest temperature on the monitor read 21 degrees centigrade with the lowest reading -0.5 degrees centigrade. There was one item inside which when this was raised with the manager was removed and destroyed. The refrigerator was marked as out of use during our inspection.
 - An action plan was received from InHealth which identified a monitored refrigerator was now in use for storage of medicines whilst a replacement was purchased for the department.
 - Medicines, including intravenous saline, were stored securely. No controlled drugs were stored and/or administered as part of the services provided in this unit. We witnessed staff using The Society of Radiographers (SoR) recommended "Paused and Checked" system to check medications prior to administration.
 - Radiopharmaceuticals were used by the department for injection. Radiopharmaceuticals for injection were regulated by the Administration of Radioactive Substances Advisory Committee (ARSAC) and authorised for injection by local consultant radiologists who hold ARSAC certificates. The local ARSAC certificate holders authorise each referral, specifying which injection is required. The amount injected in terms of radiation dosage is taken from the ARSAC guidance notes which have national diagnostic reference levels (DRLs) for each radiopharmaceutical. DRLs were displayed in the dispensing lab as a reference for the radiographers. The radiopharmaceuticals were stored in a locked dispensing lab. The suppliers of the radiopharmaceuticals provided a quality assurance certificate for every dispensed batch of their radiopharmaceutical product and both suppliers were available via telephone if there are any quality issues or queries; one of the suppliers was housed in the building adjoining the NISIC, allowing staff to speak to suppliers in person. Adverse reactions to the injected radiopharmaceutical were rare, but should they occur the ARSAC certificate holders were available on site for support and advice.
 - Staff were trained on the safe administration of radiopharmaceuticals. We reviewed staff competency files and saw all staff had received this training. We observed three patients during our inspection, all patient allergies were documented and checked on arrival in the unit.
 - Patient group directions (PGDs) were used for administration of saline to flush a cannula site pre and post radiopharmaceutical administration. PGD's allow some registered health professionals (such as radiographers) to give specified medicines to a predetermined group of patients without them seeing a doctor. We saw, in staff training files, where staff had been assessed as competent.
 - An on-site pharmacist was available for assistance and advice locally if required. InHealth had a consultant pharmacist who issued guidance and support at a corporate level and worked collaboratively with the InHealth clinical quality team on all issues related to medicines management.
 - Staff told us they would contact the onsite pharmacist initially if they had any concerns.
- ## Incidents
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and

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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.

- There were no never events reported for the service from June 2017 to July 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 June 2017 to July 2018 as defined by NHS England Serious Incident Framework 2015. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations 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.
 - There were local procedures in place to ensure, that radiation incidents were fed into risk management and that exposures ‘much greater than intended’, were notified to CQC IR(ME)R team under IR(ME)R or to Health and Safety Executive (HSE) under IRR99 requirements.
 - There were no IRMER/IRR reportable incidents reported for the service from June 2017 to July 2018. Medical ionising radiation includes x-rays and nuclear scans, and treatments such as radiotherapy. It is widely used in hospitals, dentists, clinics and in medical research to help diagnose and treat conditions. Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) sets out the responsibilities of duty holders (the employer, referrer, IR(ME)R practitioner and operator) for radiation protection. For example: minimising unintended, excessive or incorrect medical exposures ensuring the benefits outweigh the risks of each exposure (justification) keeping doses in diagnostics “as low as reasonably practicable” for their intended use (optimisation)
- Notifiable incidents under IR(ME)R are those where a dose “much greater than intended” has been delivered to an individual and should be reported to the appropriate authority. Under-doses are not notifiable but must still be locally investigated.
- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses. Staff reported incidents using an electronic reporting system. The service had an incident reporting policy and procedure in place to guide staff in the process of reporting incidents. The service had recorded 22 incidents from June 2017 to July 2018.
 - All incidents and complaints reported through the organisations electronic risk management system were reviewed on a weekly basis within the ‘complaints, litigation, incidents and compliments (CLIC)’ group by a multi professional team of governance and operational managers. Incidents involving patient or service user harm were assessed against the ‘notifiable safety incident’ criteria as defined within regulation 20 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. Incidents that met this threshold were managed under the organisations ‘adverse events (incident) reporting and management policy’ and ‘Duty of Candour, procedure for the notification of a notifiable safety incident’ standard operating procedure. Decisions relating to organisational disclosures made both under the statutory duty of candour framework and in the wider spirit of openness and transparency were recorded within the corresponding incident or complaint record and held within the electronic risk management system
 - From reviewing the incident log, we could see staff reported incidents as per policy for example, staff had reported errors in the booking process, any concerns about confidentiality and unexpected findings. We saw evidence the service looked-for opportunities to learn lessons from these incidents. There were thorough and robust investigations, all relevant staff had been involved in the review or investigation.
 - Staff used The Society of Radiographers (SoR) “Paused and Checked” system. Referrer error was identified as one of the main causes of incidents in diagnostic radiology, attributed to 24.2% of the incidents

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reported to the CQC in 2014. The six-point check had been recommended to help combat these errors. Pause and Check consisted of the three-point demographic 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.

- Relevant national patient safety alerts would be communicated by email to all staff. All staff had to accept emails with mandatory information in them this evidenced that they had been read.
- There were local procedures in place, which were being followed to ensure where there had been critical, urgent and unexpected significant radiological findings, the radiologist produced reports as quickly and efficiently as possible, the requesting doctor and/or their clinical team to read, and act upon the report findings as quickly and efficiently as possible.
- There had been no notifiable safety incidents that met the requirements of the duty of candour regulation in the 12 months preceding this inspection. 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.
- Were an incident to occur that met the requirements of the duty of candour regulation, an organisational policy and procedure was available to staff providing guidance on the process to follow. All staff had been trained and made aware of duty of candour and what steps to follow when requirements had been reached. The online incident reporting system generated an alert when a serious incident occurred in the unit to prompt staff to consider duty of candour.
- During this inspection we spoke with one member of staff specifically about duty of candour. The staff member demonstrated to us they understood the requirements of the duty of candour regulation.

Safety Thermometer (or equivalent)

- The service used safety monitoring results well. Staff collected safety information and shared it with staff. Managers used this to improve the service.

- The service had a performance dashboard maintained on a unit level. This was updated daily and reviewed monthly by the manager and superintendent radiographer. It indicated the number of patients scanned and number of patients that did not attend. Also recorded were daily safety checks, for example: emergency buzzer, intercom, arrest trolley and unit emails.
- This was reviewed at least weekly and an action plan discussed if there were omissions or concerns

Are diagnostic imaging services effective?

Not sufficient evidence to rate 

Evidence-based care and treatment

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff assessed patients' needs and planned and delivered patient care in line with evidence-based, guidance, standards and best practice. An audit was carried out annually to assess clinical practice in line with local and national guidance.
- Relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment were delivered for example, NICE CG75 'Metastatic spinal cord compression in adults, Evidence-based indications for the use of PET-CT in the United Kingdom' (2016).
- We saw no evidence of any discrimination, including on grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation when making care and treatment decisions
- Policies procedures and staff competence ensured, in relation to diagnostic procedures involving nuclear medicines, the practitioner noted the diagnostic reference level for each adult investigation. Activity for each exposure was the optimised so it is the lowest practicable dose to the patient.

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- The service performed a monthly audit of all work undertaken by on site radiologists. This was 10% of the total number reported. For outsourced reporting 10% of all work undertaken was also audited monthly.

Nutrition and hydration

- Relatives/carers had access to hot and cold drinks whilst waiting for their relative. During our inspection we observed staff offering drinks to those that were allowed.
- We also observed staff monitoring nil by mouth patients that were awaiting scans to ensure they did not drink.

Pain relief

- Pain assessments were not undertaken in this unit. Individual patients managed their own pain and were responsible for supplying any required analgesia. We were told patients received a letter prior to the procedure advising them to continue with their usual medications.
- We observed staff asking patients if they were comfortable during our inspection.

Patient outcomes

- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- Royal College of Radiologists and College of Radiographers had developed the Imaging Services Accreditation Scheme (ISAS) to support diagnostic imaging services to manage the quality of their services and make continuous improvements; to ensure that their patients consistently receive high quality services delivered by competent staff working in safe environments.
InHealth was in the application process for ISAS status.
- The service recorded the times taken between referral to them for a scan and a scan being booked. They also recorded the time from the scan to when the scan was reported on.
- Staff audited and compared key elements of the referral and scanning pathway and these were benchmarked with other InHealth locations.

- Audits of the quality of the images were undertaken at a corporate level and by the imaging provider. Any issues were fed back to local services for learning and improvement.
- Internal Healthcare quality audits were undertaken annually and assisted in driving improvement and giving all staff ownership of things that go well and that needed to be improved. The service audited 14 individual areas including, patient experience, health and safety, medical emergency, safeguarding, equipment and privacy and dignity.
- We reviewed the July 2018 audit compliance was 95% overall. Environment and Health and Safety were scored at 81% and 84% respectively. This was reported in a noncompliance summary and actions identified and completed. For example, the environment in the upstairs offices were identified as too warm for staff during the summer, this was subsequently addressed with the addition of portable air conditioning units. A health and safety concern related to the monitoring and assessment of lead apron integrity this had been addressed with a check sheet for staff to complete and a reminder to staff to report any concerns.
- Local audits of handwashing, uniform and health and safety were carried out quarterly in the unit. A patient unit entry pathway audit was carried out monthly by the unit superintendent. We saw evidence of these audits and action plans were produced if required.

Competent staff

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff had the right skills and training to undertake the MRI scans. This was closely monitored on a corporate level and by the registered manager. Skills were assessed as part of the recruitment process, at induction, through probation, and then ongoing as part of staff performance management and the InHealth appraisal and personal development processes.

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- All radiographers were Health and Care Professions Council (HCPC) registered and met standards to ensure delivery of safe and effective services to patients.
- Local induction for all staff ensured their competency to perform their required role within their specified local area. For clinical staff this was supported by a comprehensive competency assessment toolkit which covered key areas applicable across all roles including equipment, and then clinical competency skills relevant to their job role and experience.
- Staff we spoke with told us InHealth had a comprehensive internal training programme for PET-CT aimed at developing PET-CT and radiation specific competence following qualification as a radiographer.
- There were clear records showing who was entitled to administer radioactive medicinal products (RMP) together with the necessary licences as required under IRMER.
- Staff had the opportunity to attend relevant courses to enhance the professional development and this was supported by the organisation and managers. InHealth offered access to both internal and externally funded training programmes and apprenticeships to support staff in developing skills and competencies relevant to their career with InHealth.
- Radiographers scanning performance was monitored through peer review and issues were discussed in a supportive environment. Radiologists also fed back any perceived issues with scanning to enhance and learning or improvements in individual performance. The service undertakes periodic competency assessments for radiographers. In the event of any aspect of competency falling short, the practitioner's line manager was responsible for providing necessary support and guidance to enable them to reach the correct standard.
- Staff had regular meetings with their manager and a performance appraisal biannually in October to set goals and April to review them. Records we checked showed all staff in the service had received their appraisals.
- Staff of different kinds worked together as a team to benefit patients. Doctors and other healthcare professionals supported each other to provide good care.
- The unit worked closely with the referring NHS trusts this provided a smooth pathway for patients.
- The service had good relationships with other external partners and undertook scans for local NHS providers. We saw good communication between services and there were opportunities for staff to contact refers for advice and support. All patients were screened for previous radiation exposure, this was recorded and discussed with referring consultants to ensure patients were not exposed to further radiation unnecessarily. Scans could be retrieved from other areas if required.
- We were told and saw InHealth and trust staff work very closely together.
- Specialist lung consultants from the local cancer network said, "they were very impressed with the service InHealth provided to their patients".

Seven-day services

- The unit was operational Monday to Friday 8am to 5pm, Saturdays on an adhoc basis to assist with waiting lists if required. No clinical emergency patients are scanned within the service.
- Appointments were flexible to meet the needs of patients, they were available at short notice.

Health promotion

- Information leaflets such as understanding your PET-CT scan were sent to patients with their appointment letters and were available in the waiting rooms. These leaflets included information about what the scan would entail and what was expected of the patient before and after the scan appointment.
- Health promotion information leaflets and posters on subjects such as smoking cessation services and information on living with dementia, stroke and cancer were on display in the waiting rooms. The service also provided a range of information leaflets for patients and relatives, including dementia UK which patients could take away.

Multidisciplinary working

Consent and Mental Capacity Act

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- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.
- Staff demonstrated to us a good understanding of the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Mental Capacity Act awareness training was a mandatory training requirement for all staff. At the time of this inspection all staff had completed this training.
- A consent policy written in line with national guidance was available to all staff. We reviewed three patient care records and saw all patient records included a consent to treatment record. We observed staff obtaining verbal consent from the patients during their treatment.
- Staff had received training on mental capacity. They were aware of what to do if they had concerns about a patient and their ability to consent to the scan. They were familiar with processes such as best interest decisions.
- During the time of this inspection there were no patients who lacked capacity to make decisions in relation to consenting to treatment. Where a patient lacked the mental capacity to give consent, guidance was available to staff through the provider consent policy. In addition to this, staff told us they would encourage a patient to be accompanied by a family member or carer for support. If required the unit had access to an external interpreting and/or translation service for those patients whose understanding was limited due to a language barrier.
- Staff told us of one patient receiving treatment at this unit who was living with dementia and had changeable capacity. The relative attended the unit with the patient for support.
- The staff we spoke with were aware of the need for consent and gave patients the option of withdrawing their consent and stopping the scan at any time. Patients we spoke confirmed their consent had been obtained throughout the scanning process.

Are diagnostic imaging services caring?

Compassionate care

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- During this inspection we observed all staff treating patients with dignity, kindness, compassion, courtesy and respect. Staff introduced themselves prior to the start of a patient's treatment, interacted well with patients and included patients during general conversation. The reception desk was far enough away from then waiting area that patients could speak to the receptionist without being overheard.
- Staff demonstrated a kind and caring attitude to patients. This was evident from the interactions we witnessed on inspection and the feedback provided by patients.
- Staff introduced themselves and explained their role and went on to explain what would happen next.
- Staff ensured that patients privacy and dignity was maintained during their time in the facility and CT scanner. There were notices displayed informing patients that they may have a chaperone if required.
- Patient satisfaction was formally measured through completion of the company 'Friends and Family Test' following their examination. Between June 2017 and May 2018 1,535 cards had been completed of these 1,508 (98%) were extremely likely or likely to recommend the service.
- The feedback was analysed by an external, independent provider and the results and a dashboard sent to the clinical quality team. Data was provided on number of returns; patient satisfaction percentage and all comments were recorded. These were available weekly on the InHealth intranet. This enabled the manager to use the positive comments to praise the staff and investigate negative comments to drive actions to further improve the service.
- The service received 1139 written compliments during the period July 2017 to June 2018.

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- During this inspection we spoke with three patients about various aspects of the care they received in this unit. Without exception, feedback was consistently positive about the staff delivering the care.

Emotional support

- Staff provided emotional support to patients to minimise their distress.
- Staff supported patients through their scans, ensuring they were well informed and knew what to expect. Patients were provided with information and advice upon discharge including who to contact if they have a concern or issue.
- Staff provided reassurance and support for nervous and anxious patients. They demonstrated a calming and reassuring demeanour so as not to increase anxiety in nervous patients.
- We observed that the staff provided ongoing reassurance throughout the scan, they updated the patient on how long they had been in the scanner and how long was left. One patient we spoke with was worried about having the scan, the staff supported them throughout the time in the unit. After the scan the patient thanked the staff for their calm and supportive approach.
- We spoke with the unit staff about providing emotional support for patients. Staff felt they could signpost patients appropriately if necessary, and saw recognising and providing support to patients as an important part of their job. They recognised that scan-related anxiety could impact on diagnosis for patients and a possible delay in further treatment.

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 so that they understood the reason for attending the unit. All patients were welcomed into the area and reassured about the procedure.
- Staff recognised when patients and those close to them needed additional support to help them

understand and be involved in their care and treatment and enabled them to access this. This included for example, access to interpreting and translation services.

- The service allowed for a parent or family member or carer to remain with the patient for their scan if this was necessary.

Are diagnostic imaging services responsive?

Good 

Service delivery to meet the needs of local people

- The service planned and provided services in a way that met the needs of local people.
- The service was planned and designed to meet the needs of the patients. Information about the needs of the local population and the planning and delivery of services was agreed collaboratively with the commissioning NHS trust. The unit provided services through a contractual agreement with the referring trust and did not have direct communication with the commissioners.
- Progress in delivering services against the contractual agreement was monitored by the NHS trust through key performance indicators, regular contract review meetings, and measurement of quality outcomes including patient experience. Performance was reviewed and service improvements agreed at these meetings.
- Any issues were escalated promptly to the Senior Management Teams between both organisations and were often dealt with, within a few hours.
- Access to the unit was by established transport routes, with a bus stop at the end of the road. Patients were also able to use pay and display and accessible car parking of the trust site.
- The environment was appropriate and patient centred. There was comfortable /sufficient seating, toilets and a drinks machine.

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- Patients and those close to them could find further information or ask questions about their scan. A range of PET-CT specific leaflets were also available to patients and patients we spoke with confirmed they had accessed the leaflets.

Meeting people's individual needs

- The service took account of patients' individual needs.
- All had a strong understanding of cultural, social and religious needs of the patient
- All patients received an appointment letter or email and were encouraged to contact the unit if they had any concerns or questions about their examination.
- During examination, staff made patients comfortable. They ensured that the patient was in control throughout the examination and gave them an emergency call buzzer to allow them to communicate with staff should they wish. Microphones were built into the scanner to enable two-way conversation.
- Patients were advised should they wish to stop their examination, staff would assist them and discuss choices for further imaging or different techniques and coping mechanisms to complete the procedure. Explanations were given post examination on any aftercare of cannulation sites, hydration needs and how and where to get results of the scan.
- The service engaged with patients who were vulnerable and took actions to remove barriers when they found it hard to access or use services. For example, patients who had informed the service that they were nervous, anxious or phobic could be invited to have a look around the unit prior to their appointments, so they could familiarise themselves with the room and the scanner to try to manage their anxieties.
- The service provided imaging for inpatient and outpatients and welcomed service users with any level of mobility. Ramps were installed to gain entrance to the building. InHealth also implemented a dedicated disabled parking space outside the unit in response to patient feedback.
- A hoist was available to use from the hospital ward if needed, assistance using this equipment was provided by the hospital staff.
- Interpreters were available if the unit was informed prior to the appointment through a pre-booked service. In a clinical emergency, InHealth policy enabled staff to use language line or a family member to translate at the radiographers' discretion. Subject to appropriate screening checks.
- The imaging services manager (ISM), explained to us a project that she and a colleague had been involved in prior to managing the Nottingham unit. They took part in a project to create videos to help explain the MRI and PET-CT examination to people with learning difficulties. The videos were designed to show the whole procedure from waiting room to scan room and what the patient should expect and what they would be required to do. The links for the videos were available on a video sharing website for easy access.

Access and flow

- People could access the service when they needed it. Waiting times from referral to treatment were in line with good practice.
- Patients had timely access to scanning. The service was open five days a week between the hours of 8am and 5pm.
- Referrals were prioritised by clinical urgency and based on the agreed commissioning pathway. If patient symptoms could be due to a clinical urgency, these patients were often given an appointment within 48 hours. All two-week cancer pathway patients were scanned within one week to enable report turn around.
- The service held some slots which were filled a day prior to allow for any clinically urgent referrals, if these were not filled by urgent cases, the service utilised these appointments for patients who could be contacted at short notice.
- Should the need arise to add an urgent referral into the waiting list when no appointments were available, the unit would assess appointments filled by routine, not urgent examinations and rebook patients to make room for the clinical urgent case. The rebooked patient would be given the next available appointment to suit the patient.

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- Between June 2017 to July 2018, 84 planned procedures/examinations were cancelled for a non-clinical reason. All 84 cancellations were due to machine breakdown or other equipment failure as a result of isotope production failure.
- To help keep 'Did-Not-Attend' (DNA) rates low, administration staff telephoned each patient on the following day's list as a reminder of their appointment and the preparation that was required.
- In the reporting period July 2017 to June 2018 only 3% of patients did not attend for their appointment.
- The administration team reserve scanning slots for urgent scans as well as those on lung cancer pathway or two week wait pathway to enable timely appointments to be allocated. The administrative team booked the patient into the next available appointment using a checklist to establish basic patient information, this included questions regarding mobility, ability to consent, diabetic status, transport arrangements, height/weight. Any issues highlighted were brought to the attention of the clinical team who advised the administrative team if any special arrangements needed to be made.
- Appointments generally ran to time; reception staff would advise patients of any delays as they signed in. Staff would keep patients informed of any ongoing delays personally in the waiting area.
- During our inspection the radiopharmaceutical was delayed due to quality control safety checks, this led to delays although staff informed patients immediately and extra supplies were provided.

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.
- InHealth had a complaints handling policy and all staff completed a mandatory training course on complaints management.
- Complaints made to the trust which related to InHealth, would be forwarded by the hospitals operations manager to the registered manager for investigation and response. If the complaint was

related to both trust and InHealth, the organisation who received the initial complaint would request an investigation and response from the other party which would be integrated into the formal response.

- The service reported that they received seven complaints during the period July 2017 to June 2018. All seven were managed through the InHealth formal complaints procedure, none were upheld.
- The service worked closely with the host hospital to share information on complaints, concerns and compliments that may be relevant to the PET-CT scanning facility. The service received 1139 written compliments during the period July 2017 to June 2018.
- Within the unit, the complaints procedure was displayed for all patients and relatives to read and follow should they wish. If they needed further information, staff told us they would explain the procedure to them and write any contact information required to issue the formal complaint.
- Staff were encouraged to resolve complaints and concerns locally, which was reflected in the low numbers of formal complaints made against the service.
- As a response to patient and relatives concerns regarding the patient waiting area a drinks machine was installed, magazines provided and the area was warm for relatives waiting for scans to be completed.

Are diagnostic imaging services well-led?

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 InHealth management structure within the unit consisted of one FTE imaging services manager and two senior radiographers who were on site daily to assist with clinical issues, work and scan. These were supported by a regional Head of Imaging Services. The Imaging Service manager (ISM) was an experienced

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and competent senior radiographer. She appeared capable and knowledgeable in leading the service. She was enthusiastic and was keen to improve the quality and service provided. She stated she was supported and empowered by InHealth to take forward initiatives and adjust the service if warranted.

- The manager was visible and approachable. She worked alongside other staff within the facility and was clearly proud of the team.
- Staff we spoke with found the manager to be approachable, supportive, and effective in their roles. They all spoke positively about the management of the service.

Vision and strategy

- The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff.
- InHealth had four clear values: Care, Trust, Passion and Fresh thinking. These values were central to all the examinations and procedures carried out daily. Following the company mission to 'Make Healthcare Better' enabled all employees to offer a fresh, innovative approach to the care they delivered.
- All staff were introduced to the core values at the corporate induction and were familiar with them during our inspection. The appraisal process for staff was aligned to these values and all personal objectives discussed at appraisal were linked to the company's objectives.
- Staff in the service were invested in and committed to this vision. They understood the part they played in achieving the aims of the service and how their actions impacted on achieving the vision.

Culture

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The staff we spoke with were very positive and happy in their role and stated the service was a good place to work.

- Staff reported they felt supported, respected and valued on a local and corporate level. Staff stated they felt empowered to make suggestions, make changes and improvements and this was actively encouraged.
- Staff demonstrated pride and positivity in their work and the service they delivered to patients and their service partners. Staff were happy with the amount of time they had to support patients and that was one of the things they enjoyed about their role.
- There was a positive approach to reporting incidents and the service demonstrated learning outcomes and changes being implemented in response to incidents. Staff described a 'no blame' culture.
- There was good communication in the service both from a local managers perspective and at corporate level. Staff stated they were kept informed by various means, such as newsletters, team meetings and emails.
- Formal minuted team meetings were held quarterly. We were provided with minutes from these meetings which included; new staff introduction and recruitment update, Progress against strategy, quality, safety and wellbeing, financial, site update, clinical governance, policies, sentinel and complaints review/ lessons learnt, review schedule changes.
- Informal meetings were held at least weekly to discuss day to day working plans and schedules.
- Staff told us there were good opportunities for continuing professional development (CPD) and personal development in the organisation. They also stated they were supported to pursue development opportunities which were relevant to the service.
- Staff also told us teamwork was excellent both within the unit and with the host hospital. They felt this enhanced a seamless transition for patients.
- One senior member of the trust nuclear medicine team confirmed that they worked very closely with the staff at the PET-CT centre. "We are mutually supportive of joint and individual initiatives to improve patient experience and staff wellbeing and we work together to resolve any issues or incidents".

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- Equality and diversity were promoted within the service and were part of mandatory training, inclusive, non-discriminatory practices were promoted.
- A whistle blowing policy, duty of candour policy and appointment of two freedom to speak up guardians supported staff to be open and honest. Staff told us they attended duty of candour training and described to us the principles of duty of candour.
- All independent healthcare organisations with NHS contracts worth £200,000 or more are contractually obliged to take part in the Workforce Race Equality Standard (WRES). Providers must collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality. A WRES report was produced for this provider in September 2017 including data from June 2016 to June 2017.
- There was clear ownership of the WRES report within the provider management and governance arrangements, this included the WRES action plan reported to and considered by the Board.
- InHealth identified that staff ethnicity was not previously captured in the staff survey and self-reporting of ethnicity was low. There was no comparative data for 2016 as a result of this. The action plan stated that this would be included within the 2018 report (not yet published).

Governance

- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.
- There was an effective corporate and local governance framework which oversaw service delivery and quality of care. Internal healthcare quality audits were undertaken annually and assisted in driving improvement and giving all staff ownership of things that go well and that needed to be improved. Staff were supported in incident reporting, complaint handling and developing local policies and protocols as well as implementing corporate policies and procedures. All disciplines were professionally accountable for the service and care that was delivered within the unit.
- Corporate governance meetings were undertaken every three months and minutes were recorded from these meetings. We reviewed minutes and meeting notes, there was evidence of discussions regarding incidents, complaints, policies, performance and updates from sub committees.
- InHealth operated a comprehensive clinical governance framework which aimed to assure the quality of services provided. Quality monitoring was the responsibility of the location registered manager and was supported through the InHealth clinical quality team through the framework and governance committee structure. This included a quarterly risk and governance committee, clinical quality sub-committee, medicines management group, water safety group, radiation protection group, radiology reporting group and a weekly meeting for review of incidents and identification of shared learning.
- The radiation protection supervisor attended a radiation protection meeting in June 2018 items discussed included staff doses, audit, annual CT testing, concerns and incidents.
- The service had local governance processes, which were achieved through team meetings and local analysis of performance, discussion of local incident, where this was applicable, this fed into processes at a corporate level. We saw minutes and meeting notes during our inspection.
- Staff were clear about their roles, what was expected of them and for what and to whom they were accountable.
- Staff working with radiation were provided with appropriate training in the regulations, radiation risks, and use of radiation. Staff we spoke with were aware of the changes made by the introduction of the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER17) which had been introduced in February 2018. Work was still ongoing to achieve compliance.
- There were processes in place to ensure staff were fit for practice, for example, they were competent and held appropriate indemnity insurance in accordance with The Health Care and Associated Professions (Indemnity Arrangements) Order 2014.

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- Working arrangements with partners and third-party providers were managed. There were service level agreements between the service and the local acute trust, the clinical commission group and a private provider. The service provided quarterly quality reports and regular meetings to discuss the service provided.

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 robust risk assessment system in place locally with a process of escalation onto the corporate risk register. The local risk register was reviewed and updated monthly and new risks added regularly. For example, medication errors were a risk. However, to mitigate this risk policies were in place incident, accident and near miss reporting system, limited availability of contrast agents and pharmaceutical, relevant PGDs in place, only appropriately trained staff permitted to administer and anaphylaxis drugs and resuscitation equipment immediately available and staff trained in use.
- The risk register included quality performance, operations, human resources, health and safety, finance, legal, IT systems, procurement and information governance. An action log was also included identifying timescales and accountability.
- Performance was monitored on a local and corporate level. Performance dashboards and reports were produced which enabled comparisons and benchmarking against other services. Information on turnaround times, 'did not attend rates', patient engagement scores, incidents, complaints, mandatory training levels amongst others were charted.

Managing information

- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service had access to both the InHealth and NHS trust organisation computer systems. They could access policies and resource material from both organisations.

- There were three computers in the unit and the manager had a laptop computer. This was sufficient to enable staff to access the system when they needed to.
- All staff we spoke with demonstrated they could locate and access relevant and key records very easily and this enabled them to carry out their day to day roles.
- Electronic patient records could be accessed easily but were kept secure to prevent unauthorised access to data.
- Information from scans could be reviewed remotely by referrers to give timely advice and interpretation of results to determine appropriate patient care.

Engagement

- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- Patient satisfaction cards were given to all those who had been scanned in the unit to gain feedback on the service received. This feedback was overwhelmingly positive.
- The service utilised the feedback and took positive action when patients identified a concern.
- Staff satisfaction surveys were undertaken annually to seek views of all employees within the organisation and actions implemented from the feedback received.
- We were provided with Midlands results for January 2018 survey which indicated for example 85% of staff said, at work, I have the opportunity to do my best every day, 90% of staff said, if one of my friends or family needed care or treatment, I would recommend InHealth's services to them, 93% of staff said, patient safety is a key priority at InHealth and 89% said, equality and diversity are valued at InHealth.
- The service engaged regularly with their partners to understand the service they required and how services could be improved. This produced an effective pathway for patients. The service also had a good relationship with local NHS trust.
- Unit staff were encouraged to voice their opinions and help drive the direction of the service provided and

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suggest improvements to the examinations provided. This was evident during our inspection in relation to the anxiety paper that had been written and taken forward.

- InHealth provided an Employee Wellbeing and Assistance Programme to offer staff support during times of crisis and ill-health.

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.
- Staff could provide examples of improvements and changes made to processes based on patient feedback, incidents and staff suggestion. Staff were

alert to new initiatives and ways of working. Patient feedback had identified a delay in transport collection of some local patients. To improve this problem, the local team had approached a local taxi firm to provide a solution for patients.

- A review of PET isotope drug reference levels (DRL's) was planned to take place in the coming year and change to weight-based injections. This would reduce dose to both staff and patients. This had been discussed with MPE's in Nottingham and is awaiting input from ARSAC certificate holders.
- InHealth were working towards accreditation with the Imaging Services Accreditation Scheme (ISAS). The director of clinical quality was leading on the accreditation.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should monitor the temperatures of fridges used for medication storage.
- The provider should ensure discussion with the local trust in relation to tamper evident emergency medicine storage.
- The provider should ensure staff adhere to InHealth policies in relation to the use of personal protective equipment (aprons) and uniform.

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.

This section is primarily information for the provider

Enforcement actions

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.