

Maidstone PET- CT Centre

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?			
Are services caring?		Good	
Are services responsive?		Good	
Are services well-led?		Good	

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 17 and 21 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 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 only service provided at this location was diagnostic imaging.

Services we rate

We rated this service as good overall.

We found the following areas of good practice:

- There was a focused and individual approach to patient care.
- We observed staff to be caring, kind and who engaged appropriately with patients.
- There was a strong team approach to multidisciplinary working.
- Staff told us they received feedback from incident reporting processes. We saw evidence of change to practice from incident investigation.

However, we found areas of practice that the service needed to improve:

- The service should consider a strategy for local risk oversight that is reviewed regularly and assures adequate responsibility, accountability and an effective management of current risks at a local level.
- Staff should always follow standard operating procedures such as the use of the occupied room warnings when patients were waiting prior to their scan.
- The service should provide information in key places such as the waiting area that offer patients advice and guidance through support groups and encourage healthy lifestyles.

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.

Nigel Acheson

Deputy Chief Inspector of Hospitals

Overall summary

This service provides diagnostic imaging services using positron emission tomography-computed tomography (PET-CT) to the local community. Alliance Medical Ltd. (AML) provides PET-CT imaging at Maidstone Hospital through a national contract commissioned with NHS England as well as through private referrals.

The service was originally delivered by AML from August 2015 using a mobile unit. The static Maidstone PET-CT

Centre opened at the beginning of September 2017 following an AML programme to transfer mobile services to static units throughout the country to improve patient experience and improve integration with local trusts.

The service uses a PET-CT scanner that has advanced software and technology which improves the detection of small lesions leading to improved patient outcomes.

Summary of findings

Patients were referred primarily, but not exclusively, from Kent Oncology Centre in collaboration with Maidstone and Tunbridge Wells NHS Trust, East Kent Hospitals University Foundation Trust, Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust. Local Governance was monitored through regular meetings with the Administration of Radioactive Substances Advisory Committee (ARSAC) holder (a specialist licensed radiologist) in Maidstone Hospital. A dual policy agreement was in place which ensured that the unit complies with both AML's overarching policies while considering the Trust's local requirements. The service was also supported by the Maidstone and Tunbridge Wells NHS Trust Medical Physics Team who provided a Radiation Protection Advisor, a Medical Physics Expert and Radioactive Waste Advisor.

The Unit Manager was also responsible for another PET-CT Centre and was supported by a Clinical Lead Radiographer/Technologist at the site who supervised the clinical staff. A team of administrators provided booking, administration and reception duties. Patients were only referred by consultants who were specialists in their field, predominantly oncology, together with cardiac patients as required.

The unit was open Monday, Wednesday and Thursday 7:30am to 7:30pm and Tuesday and Friday 8am to 6pm. To ensure sufficient capacity was available to enable patients to be scanned within the contracted time frame the unit was supported by a mobile PET-CT scanner up to twice a month when required.

Summary of findings

Our judgements about each of the main services

Service

Diagnostic imaging

Rating

Good



Summary of each main service

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.

- People were protected from avoidable harm and abuse. The service supported people to keep themselves safe and secure.
- People's outcomes and feedback about the effectiveness of the service described it as consistently good.
- People were supported and treated with dignity and respect, and were involved as partners in their care.
- People's needs were met through the way services were organised and delivered.
- The service was consistently well managed and led. The leadership, governance and culture promoted a delivery of high-quality, person-centred care.

Summary of findings

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Good



Maidstone PET-CT Centre

Services we looked at:

Diagnostic imaging

Summary of this inspection

Background to Maidstone PET- CT Centre

The registered provider's head office is based in Warwick, Warwickshire and commenced service in 1989. The provider registered in 2016. The Maidstone location was registered in August 2017.

The service provides diagnostic screening tests using PET-CT scanning equipment for patients aged 18 years and above.

The service has had a registered manager in post since registering with the CQC in August 2017.

Our inspection team

The team comprised a CQC lead inspector who had completed the single speciality diagnostic imaging

training and a specialist advisor. The inspection team was overseen by an Inspection Manager and Catherine Campbell Head of Hospital Inspection for the South East region.

Information about Maidstone PET- CT Centre

The location was registered to provide the following regulated activity:

- Diagnostic and screening procedures.

During the inspection, we visited the registered location which is co-located at an acute NHS hospital. We spoke with eight staff including, administration staff, radiographers, assistants and a unit manager. We observed four PET-CT scans and engaged with four patients and their relatives during these procedures. During our inspection, we reviewed four patient records. There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

The service was registered with the CQC in August 2017 and this was the first rated inspection since registration.

A 0.5 whole time equivalent unit manager, one clinical lead radiographer, three technologist/radiographers, two clinical assistants and three administrators worked at the service on permanent contracts.

Controlled medicines were not used and therefore they did not have an accountable officer for controlled drugs.

Track record on safety (October 2017 to September 2018):

- There were no never events reported.

- Two serious incidents rated as low risk and of clinical origin were reported in the period between October 2017 and September 2018.
- One IR(ME)R/IRR reportable incident of moderate risk and of clinical origin occurred between October 2017 and September 2018.
- No incidences of healthcare acquired Meticillin-resistant *Staphylococcus aureus* (MRSA).
- No incidences of healthcare acquired Meticillin-sensitive *Staphylococcus aureus* (MSSA).
- No incidences of healthcare acquired *Clostridium difficile* (C. difficile).
- No incidences of healthcare acquired *Escherichia coli* (E-Coli).
- The service had received three formal complaints and 4 formal compliments recorded between October 2017 and September 2018.

Services accredited by a national body:

The service had four accreditations by national bodies:

- ISAS awarded in July 2018 and due to be renewed in July 2021
- ISO27001 awarded in June 2018 and due to be renewed in June 2021
- IIP awarded in March 2017 and due to be renewed in March 2020

Summary of this inspection

- NCRI awarded in May 2018 and due to be renewed in May 2019

Services provided under service level agreement:

- Clinical and or non-clinical waste removal.
- Interpreting services.
- Maintenance of medical equipment.
- Support for medical emergencies.

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:

Good



- Staff received effective mandatory training in safety systems, processes and practices.
- The service had effective safeguarding systems, policies and procedures and knew how to manage safeguarding concerns promptly, using local safeguarding procedures whenever necessary.
- The service managed the control and prevention of infection well. Where the service was responsible, staff were trained and understood their role and responsibilities for maintaining high standards of cleanliness and hygiene in the premises.
- Staff were clear about their responsibilities regarding premises and equipment. They used equipment correctly to meet statutory requirements and supported people to stay safe. The design, maintenance and use of facilities and premises prevented patients from avoidable harm.
- The service embedded a proactive approach to anticipating and managing risks to people who used their services, which was recognised as being the responsibility of all staff. Staff understood these systems and strategies and used them consistently.
- There were always enough competent staff on duty. Staff had the right mix of skills to make sure that practice was safe and that they could respond to unforeseen events. The service regularly reviewed staffing levels and adapted them to people's changing needs.
- Service records and other relevant sources were regularly and systematically reviewed to check for consistency, safety-related themes and trends. These were consistently audited and discussed with staff and other stakeholders to reduce related risks.
- Arrangements were in place for the safe management of radio-active tracers that protected patients from avoidable harm.
- 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. When something went wrong, there was an appropriate thorough review or investigation that involved all relevant staff, partner organisations and people who used the service. Lessons were learnt and communicated widely to support improvement

Summary of this inspection

However:

- Staff did not always follow standard operating procedures such as the use of occupied room warnings when patients were waiting prior to their scan

Are services effective?

We currently do not rate effective. We found:

- Care and support was planned and delivered in line with current evidence-based guidance, standards, best practice, legislation and best use of technology. This was monitored to ensure consistency of practice delivered.
- Information about the outcomes of patient's care and treatment was routinely collected and monitored. The service undertook regular clinical audits 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.
- Staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment. Staff took on new responsibilities as part of their developing role and professional development.
- Staff worked collaboratively across services to understand and meet people's needs.
- The service ensured that people received information about their care and support options relating to the service provided.
- Staff judged whether people had capacity to make particular decisions whenever this was necessary. They involved relevant people and professionals when needed, and recorded their actions and assessments whenever this was proportionate and appropriate.

However:

- The service should provide information in key places such as the waiting area that offer patients advice and guidance through support groups and encourage healthy lifestyles.

Are services caring?

We rated caring as good because:

- People were treated with dignity, respect and kindness during all interactions with staff. Their relationships with staff were positive.
- The service made sure that staff had the time, information and support they need to provide care and support in a compassionate and person centred way.

Good



Summary of this inspection

- The service provided sufficient time for staff to develop trusting relationships with people, their families, friends and other carers. Staff noticed when people were in discomfort or distress and took swift action to provide care and support.

Are services responsive?

We rated responsive as good because:

- People's needs were met through the way services were organised and delivered.
- People's needs were identified, including needs on the grounds of protected equality characteristics, and their choices and preferences and how these were met. These activities were regularly reviewed and drove service development.
- Patients had timely access to diagnostic imaging scanning.
- The service used the learning from complaints and concerns as an opportunity for improvement. Staff could give examples of how they incorporated learning into daily practice.

Good



Are services well-led?

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 with quality and safety as the top priority.
- The service had a positive culture that was person-centred, open, inclusive and empowering. Leaders, managers and staff had a well-developed understanding of how they prioritise safe, high-quality, compassionate care.
- There were governance frameworks that support the delivery of good quality care. 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 and action plans were identified on how to address things that needed to be improved.
- Management systems could identify and manage risks to the quality of the service. The service used the information to drive improvement within the service.
- Electronic patient records were kept secure to prevent unauthorised access to data. Authorised staff demonstrated they could be easily accessed when required.
- There was a strong focus on continuous learning at all levels of the organisation. Staff had objectives focused on improvement and learning. Leaders, managers and staff considered information about the service's performance and how it could be used to make improvements.

Good



Summary of this inspection

However:

- There was no local active risk register. The service relied on a biannual risk assessment system with a process of escalation onto the corporate risk register.





Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	N/A	Good	Good	Good	Good

Diagnostic imaging

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Good 

Are diagnostic imaging services safe?

Good 

We rated this service as **good**.

Mandatory training

- **Staff received effective mandatory training in safety systems, processes and practices.**
- Mandatory training met the 90% compliance standard expected by the service. We saw 90% of staff across Alliance Medical Ltd. (AML) were compliant with their mandatory training.
- AML provided all staff at all levels with clear mandatory training guidelines and facilitated access to training. This was supported by documents such as the “AML Permanent Staff Training Needs Analysis” which identified which mandatory training modules were required for each member of staff, as well as stating their review periods, which modules were available online or face to face and which modules could be completed online or needed to be arranged face to face. Most training was delivered as an e-learning module.
- Staff had an individual contemporaneous training record always available and this was regularly reviewed by their line manager. Staff were notified by email when they needed to book an update their training 60 days and 30 days prior to their training expiring. We reviewed three training records. All were complete. We saw on one record how the advisory prompt for an upcoming training module was used and how it indicated the need to complete the training module before an established deadline.
- Mandatory training subjects included: complaints handling, basic life support, conflict resolution, equality

and diversity, fire safety at work, health and safety awareness, infection control, information governance, managing violence and aggression, manual handling objects, medicines management in imaging and moving and positioning patients.

- We saw how the mandatory equality and diversity training provided staff awareness of the potential needs of patients with any of the following needs: mental health, learning disabilities, autism and dementia.
- All staff working at the service had completed the local induction process that covered local requirements such as knowledge of the local rules, fire evacuation plan, local staff facilities and access codes to relevant areas. The induction process also included the completion of mandatory training modules relevant to each professional.
- 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 (IR(ME)R17). They were able to direct us to sources of these regulations both online and within the site folder.
- Staff could direct us to the standards of practice (SOP) available on the intranet and site folder.

Safeguarding

- **The service had effective safeguarding systems, policies and procedures and knew how to manage safeguarding concerns promptly, using local safeguarding procedures whenever necessary.**
- 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

Diagnostic imaging

effective safeguarding adults' policy 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).

- The service had a system in place to ensure there were always staff members on duty with the correct level of safeguarding training. At the time of the inspection 100% of staff had been trained in safeguarding children level one and two. The unit did not treat patients who were under the age of 18. This met intercollegiate guidance 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff' (March 2014). Guidance states all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers should be trained to level two. All staff had been trained in safeguarding adults level one and two.
- Contact numbers for local adult and child safeguarding referrals were displayed in the control room and in the administration and manager's office.
- Processes were in place so that 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.

Cleanliness, infection control and hygiene

- **The service managed the control and prevention of infection well. Where the service was responsible, staff were trained and understood their role and responsibilities for maintaining high standards of cleanliness and hygiene in the premises.**
- 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 and appropriate waste management. The registered manager was the infection control lead for the service.
- There had been no incidences of a healthcare acquired infection between September 2017 to October 2018.
- We saw 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. Our findings were in line with the Maidstone PET-CT Centre Annual Infection Prevention and Control Report August 2018

- Maidstone PET-CT Centre was subject to regular IPC monitoring requirements in accordance with policy and procedure. The unit achieved and maintained a good standard across all areas. The centre achieved a score 90% in the annual IPC audit in the December 2017 audit. The December 2018 audit had not yet been published however review of the most recent monthly data indicated compliance with the 90% target.
- The 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 appropriate cleaning procedures in place for all PET-CT equipment, following its use.
- We observed staff to be compliant with best practice regarding hand hygiene and staff were noted to be bare below the elbow. There was easy access to hand washing facilities throughout the service. We observed staff washing their hands using correct hand hygiene techniques before, during and after patient contact. Patients told us staff always washed their hands prior to attending to them. Hand sanitiser gels were available in the 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. A hand hygiene audit had been completed for all clinical staff every month during the reporting period between July 2017 to July 2018, the mean score was 98%. Hand hygiene results were communicated to staff at team meetings and through email and actions identified to achieve 100% compliance in future audits.
- We saw sharps disposal bins (secure boxes for disposing of used needles) located appropriately across the

Diagnostic imaging

service ensuring the safe disposal of sharp items. They were all clean and not overfilled. Labels were correctly completed to inform staff when the sharps disposal bin had been opened.

- Staff were trained in cannulation and explained to us the need to monitor cannula sites. They also told us about the process, for removing the cannula and we observed them disposing of them correctly in a contaminated sharps container.
- Staff participated in the Insertion of Peripheral Vascular Device (PVD) audit every month during the reporting period between November 2017 to September 2018. The mean score was 97%. No areas of concern were noted in the report.
- Infectious patients were not restricted by the patient referral pathway for Maidstone PET-CT Centre. When infectious patients were referred to the service they were managed in compliance with policy and reported via the incident reporting policy to allow a trend analysis. For example, policy suggested that infectious patients were booked in the last slots of the day, unless urgent, and deep cleaning was carried after the scan. No trends had been identified and no areas of concern had been noted in the 12 month reporting period between November 2017 and September 2018.
- All staff were compliant with the on-line annual IPC training module.
- Legionella testing was carried out as per local policy. This was in line with the Health Technical Memorandum 04-01 (2006): The Control of Legionella, Hygiene, "Safe" Hot Water, Cold Water and Drinking Systems.
- An annual deep clean was carried out by an external service through a corporate contract. We saw evidence to assure us this had been completed.

Environment and equipment

- **Staff were clear about their responsibilities regarding premises and equipment. They used equipment correctly to meet statutory requirements and supported people to stay safe. The design, maintenance and use of facilities and premises prevented patients from avoidable harm.**
- The layout of the unit was compatible with health building note (HBN06) guidance. Health building notes give best practice guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities.

- Parking was available on site at the acute trust.
- The service was accessible through a site entrance on the side of the building leading on to a reception area or through the acute hospital's nuclear medicine department. There was clear signage and visual prompts to assist patients and visitors attending the service. Access to clinical areas were protected with doors secured with a keypad entry system and clear signage including identification of "hot rooms" and radiation areas.
- Maintenance and use of equipment protected patients from avoidable harm. We looked at six items of equipment. They all had a sticker indicating when they were last serviced and when the next service was due. Equipment we looked at had an up to date service record which provided information on when an item was due to be serviced.
- The service used equipment to prepare radio-active tracer doses. This was a unidose fully automated dose dispensing system. This equipment prepared radio-active tracer doses and injections precisely in aseptic conditions, using combined weight and activity measures, tailored to the patient's details. Staff using this equipment had received training in safe management and operation of the equipment by the manufacturer and the equipment was also maintained by the manufacturer.
- The service used a modern PET-CT scanner. The scanner used advanced technology to improve lesion detectability in smaller nodules, reducing patient radiation dose. This technology also helped reduce scan times for longer imaging procedures. For example, 'total body scans' took approximately 35 to 40 minutes compared to 50 to 60 minutes (on previous 2D scanners).
- A control/observation area allowed visibility of all patients during the scan and close circuit televisions allowed staff to observe and monitor patients in the treatment rooms following administration of fluorodeoxyglucose (FDG) or fluoroethylcholine (FEC).
- 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 buzzer during scanning. A microphone allowed constant contact between the radiographer and the patient.
- Arrangements for managing radioactive and clinical waste protected patients from avoidable harm. This included classification, segregation, storage, labelling,



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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 and each waste bag was tagged and recorded for activity monitoring daily.

- The systems, processes and practices that were essential to prevent patients from avoidable harm were identified, put in place and communicated to staff. Implementation of safety systems, processes and practices were monitored and improved when required. For example, “hot waste” within controlled areas was only left for 72 hours. If there was a high risk associated to the waste it would be locked in a safe cupboard.
- 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. The resuscitation trolley was owned and managed by the local trust and was located within the service. Daily and weekly checks were carried out by the service’s staff and we saw evidence that demonstrated the equipment was safe and fit for use. There were procedures and an agreement with the local trust crash team for removal of a collapsed patient. A crash team is a medical team with specialist equipmentable to mobilise quickly to treat cardiac arrest.
- The service had arrangements in place to ensure that the premises restricted access and had control to the areas 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 physical barrier was put across the door when the PET-CT was in use. Chemical products deemed as hazardous to health were in locked cupboards or rooms that were only accessible to authorised staff.
- Patients could access emergency pull cords easily in areas where they were left alone, such as toilets and treatment rooms. Call bells were available within the scanning room which patients could press if they wanted the scan to stop.
- There was twenty-four-hour, seven-day picture archiving and communication system (PACS) support, there were backup arrangements in the event of an IT failure.

Assessing and responding to patient risk

- **The service embedded a proactive approach to anticipating and managing risks to people who used their services, which was recognised as being the responsibility of all staff. Staff understood the systems and strategies and used them consistently.**
- We saw comprehensive risk assessments carried out for patients and risk management plans developed in line with national guidance. For example, we saw evidence of an extensive patient safety questionnaire being completed prior to any scan. Risks were managed positively and updated appropriately where a change in the patient’s condition was required, for example managing a patient who was very anxious about the procedure or had a needle phobia.
- No patients had required urgent transfer for emergency care between October 2017 and September 2018.
- Staff used The Society of Radiographers “Paused and Checked” system to reduce the risk of referrer error. 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.
- The potential risks of intravascular administration of the radio-active tracers fluorodeoxyglucose or fluoroethylcholine were assessed against the potential benefits. Systems were in place which included trained individuals that can recognise and treat severe reactions, including anaphylaxis.
- Clinical staff told us they felt confident to identify and respond appropriately to changing risks to patients who use services, including deteriorating health and wellbeing or medical emergencies. All clinical staff had received immediate life support training.
- Staff had clear pathways and processes to assess patients using the services who were clinically unwell and needed hospital admission. For example, this was documented in the AML Management of Medical Emergencies Policy and Procedure where pathways were available to guide staff in referring patients to an emergency department.
- Radiation risks to patients were managed in line with guidance from the International Atomic Energy Agency,

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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.

- 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. We saw evidence if the possibility of pregnancy could not be excluded, the patient was asked whether her menstrual period was overdue. Low dose procedures could continue to be undertaken, provided that the women's period was not overdue, which met national guidance. Information was sent out to the patient at the time of booking the appointment and there were notices up in the reception, waiting area and corridors.
- The service had named staff fulfilling the essential roles of radiation protection advisor, medical physics expert, radiation protection supervisor, senior radiologist and infection control lead. Staff said the radiation protection advisor and the medical physics expert were readily accessible online or through the telephone for providing radiation advice.
- There were local rules (IRR) and employer's procedures in place (IR(ME)R) which protected staff and patients from ionising radiation. We saw signs in the radiation department waiting area informing people about areas or rooms where radiation exposure took place. Additionally, staff and patients were issued with radiation monitors to display exposure to radiation throughout the delivery of services or stay.

Staffing

- **There was always enough competent staff on duty. Staff had the right mix of skills to make sure that practice was safe and that they could respond to unforeseen events. The service regularly reviewed staffing levels and adapted them to people's changing needs.**
- There were sufficient numbers of staff with the necessary skills, experience and qualifications to meet patients' needs. An AML staffing requirement calculator to support a safe scanning pathway standard of practice 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 numbers were to be calculated and managed at unit level. To achieve this the minimal amount of staff required locally for a full scanning day was two technologists/radiographers and one clinical assistant, having minimum of two staff qualified in the management of medical emergencies and recognition of the deteriorating patient, to provide a safe service to patients. All staff had completed relevant clinical competency assessments in relation to their role. To support patient safety, all members of staff had been ILS trained, undertaking courses recognised by the Resuscitation Council UK (RCUK).

- Staffing at the service comprised of a 0.5 whole time equivalent (WTE) unit manager, one clinical lead radiographer, three technologist/radiographers, two clinical assistants and three administrators who worked at the service on permanent contracts..
- The staffing policy ensured the service operated safely and effectively, with the appropriate number of staff and correct skill mix levels required to facilitate safe care.
- The service had a 'lone working' policy. However, staff told us this was not used as staffing levels were managed adequately. This ensured that an individual member of staff did not undertake any work in isolation from another member of staff. This allowed staff to take regular breaks to ensure that adequate rest was maintained. To support the calculation of local staff requirements in the different roles, the service used a staff calculator. This ensured sufficient staff were available during operational periods.
- At the time of inspection, there were no vacancies within the service.
- Between November 2017 and September 2018, the average sickness rate for the service was reported as 4.3% for administrators.
- The service used three bank shifts in the last three months to cover times of staff shortage of technologists/radiographers between October 2018 and September 2018. We were told, if bank or agency staff were used, prior to undertaking any shifts, they had to complete a period of induction and have proof of completion of mandatory training relevant to the position they were required to fill. Previous equipment experience was also used to establish suitability.

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- The unit manager was also the manager for another diagnostic unit relatively locally and could flex regular staff cover across both units to cover leave. This ensured staff continuity and familiarity with the unit.
- The service was managed by an experienced operational manager, supported by regional management and central support functions, to maintain 24-hour accountability for safe and appropriate staffing levels.

Medical staffing

- The service did not employ any medical staff. All reporting consultants worked for local NHS trusts.

Records

- **Service records and other relevant sources were regularly and systematically reviewed to check for consistency, safety-related themes and trends. These were consistently audited and discussed with staff and other stakeholders to reduce related risks.**
- Patients' individual care records were written and managed according to best practice. This was in line with NICE QS15 Statement 12: Patients experience coordinated care with clear and accurate information exchange between relevant health and social care professionals.
- We reviewed four patient records. Records were accurate, complete, legible, up to date and stored securely. Records were electronic and available for access by staff. Paper records such as paper referrals were shredded as per policy once the information was uploaded.
- The radiology information system (RIS) and picture archiving and communication system (PACS) used by the service was secure and password protected. Each member of staff had their own personally identifiable password.
- Patient and clinical information was recorded on the provider's electronic records system. This system was not integrated with the referrer's data management system, however there was a secure system in place to ensure necessary information was shared such as reports and images from the PET-CT Scan. The report

was also shared with the commissioner via a secure NHS.net account for administration purposes. This process was managed by the provider's image transfer team and case management.

- The quality of images was peer reviewed locally by the acute trust and quality assured at 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.

Medicines

- **Arrangements were in place for the safe management of radio-active tracers that protected patients from avoidable harm.**
- The service obtained, prescribed, recorded, handled, stored, dispensed and disposed of fluorodeoxyglucose (FDG) and fluoroethylcholine (FEC) in a safe manner and according to the provider's standard operating procedures.
- The service ensured that the medicines (administration of radioactive substances) regulations 1978 [MARS], were taken account of. An administration of radioactive substances committee (ARSAC) certificate holder, the lead consultant based at the local acute trust, worked closely with the service and provided cover for the examinations they performed.
- We were assured there were sufficient checks to ensure patients received the correct dosage of the radioactive drug, or tracer. A PET scan uses a small amount of a radioactive drug, or tracer, to show differences between healthy tissue and diseased tissue. The most commonly used tracer is called FDG, so the test is sometimes called an FDG-PET scan. Before the PET scan, a small amount of FDG is injected into the patient. There were processes in place to ensure the right radiopharmaceutical was injected. Additionally, the service used a radio-active tracer unidose dispenser machine which assured that when the radiopharmaceutical was dispensed, drawn up and level of radioactivity measured this was correct. An additional final four or five-way check immediately prior to injection of patient verses, demographics, verses intended exam, verses radioactive medicinal products (RMP) identity verses RMP activity, was used as a 'fail-safe'.
- Staff stored medicines securely within a designated room and these were stored at the correct temperatures, in line with the manufacturers' recommendations, to ensure they would be fit for use.

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- Staff were trained on the safe administration of intravenous FDG and FEC. We reviewed staff competency files and saw that all staff had received this training. We observed three patients receiving intravenous FDG during our inspection. Their allergies were documented and checked on arrival in the unit.
- The service did not use any controlled medicines for any of their procedures and therefore did not require a controlled medicines policy to be in place.
- The service did not use Patient Group Directives.
- The Society of Radiographers recommended “Paused and Checked” system was used to check medications prior to administration.
- Emergency medicines were available in the event of an anaphylactic reaction. These were in date and checked.
- The registered manager was the service lead for the safe and secure handling of medicines.
- Patients were given information post scan which documented which medications they had been given. This directed patients to seek advice from their GP or A&E if they felt unwell after leaving the unit and explained how they should show the information regarding what they had received.
- The pharmacy team at the local acute trust was available for assistance and advice locally if required.
- The service had a consultant pharmacist who issued guidance and support at a corporate level and worked collaboratively with the clinical quality team on all issues related to medicines’ management.
- Medication and disposal was provided by an external company on a contract.
- There were no never events reported for the service from September 2017 to October 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 two 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. We were assured these incidents were investigated rigorously and action plans were implemented to address the issues. These were appropriate and no reoccurrence of the incidents had happened since.
- There was one IR(ME)R/IRR reportable incident of moderate risk and of clinical origin occurred between October 2017 and September 2018. We were assured this incident was investigated rigorously and action plans were implemented to address the issue. The action plan was appropriate and no reoccurrence of the incident had happened since.
- The service had recorded 55 incidents from October 2017 to September 2018. Of these 55 incidents three were graded as moderate risk the remaining incidents were graded as low risk or very low risk. Two incidents were not rated. The classification of the incidents was as follows:

- 27 incidents were classified as the result of a clinical issue such as extravasation and patients being unwell.
- 1 incident was reported as a health and safety issue.
- 3 incidents were reported as information governance issues.
- 10 incidents were reported as operational issues such as equipment failure.
- 12 incidents were reported as radiation protection issues
- 2 incidents were safeguarding issues. For example, patient came from the acute hospital without an escort or without food, drink and medication.
- We saw the service looked for opportunities to learn lessons from these incidents.
- We reviewed 3 reported incidents. All incidents were recorded, reviewed and investigated with trends identified and actions raised at a national and regional level. All serious incidents were reported within 24 hours

Incidents

- **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. When something went wrong, there was an appropriate thorough review or investigation that involved all relevant staff, partner organisations and people who used the service. Lessons were learnt and communicated widely to support improvement.**
- 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.

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and a root cause analysis (RCA) investigation undertaken. RCA investigation reports were reviewed at the relevant sub-committees who were responsible for making sure that appropriate remedial action and shared learning had taken place. During 2017 a new pathway for 'escalated events' was introduced to track incidents which the organisation considered required a more in-depth level of investigation to support prevention.

- 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. 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. The service had a duty of candour policy in place. The policy defined when the principles of duty of candour should be followed.

Are diagnostic imaging services effective?

We do not rate effective.

Evidence-based care and treatment

- **Care and support was planned and delivered in line with current evidence-based guidance, standards, best practice, legislation and best use of technology. This was monitored to ensure consistency of practice.**
- We saw evidence that relevant and current evidence-based guidance, standards, best practice and legislation was used to identify and develop how services, care and treatment were delivered. We were assured that the standards of practice available to staff on the intranet and in the site folder were up to date and referenced the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R17).
- Patients had their needs assessed and their care and treatment was planned and delivered in line with

evidence-based guidance, standards and best practice. Relevant and current evidence-based guidance, standards, best practice and legislation identified and were used to develop how services, care and treatment were delivered for example, evidence-based indications for the use of PET-CT in the United Kingdom' (2016). We were assured staff were aware of the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R17).

- Staff followed local rules procedures for dose reference levels. We saw how policies, procedures and staff competence ensured the effectiveness of diagnostic procedures involving nuclear medicines. For example, the practitioner noted the diagnostic reference level for each adult investigation. Activity for each exposure was then optimised so it was the lowest practicable dose to the patient.
- All PET-CT reporters were included in the national programme audit scheme. This was a randomised 10% surveillance audit undertaken by auditors independent to the reporting clinicians. For National Health Service Executive (NHSE) programme sites such as Maidstone PET-CT Centre this was a centrally coordinated audit process. The results were held centrally, with feedback provided throughout the year to reporters to allow for reflection of practice.
- Staff conducted quality control reviews every morning for PET-CT scans. This was reported on a cumulative spreadsheet which allowed for the reporting of any anomalies. Checks were conducted by the local radiation protection advisor. Additionally, every week the physics team do a check on the PET-CT machine.

Nutrition and hydration

- There were no nutrition services provided by the unit for patients that attended for PET-CT scans. However, patients had access to tea and coffee services in reception and in the reception area. Staff encouraged patients to have some biscuits which they provided following the scan as patients often had to avoid eating for the scan.

Pain relief

- Patients were asked by staff if they were comfortable during their appointment, however no formal pain level monitoring was undertaken as procedures undertaken were pain free.

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Patient outcomes

- **Information about the outcomes of patient's care and treatment was routinely collected and monitored. The service undertook regular clinical audits 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.**
- All PET-CT reporters were included in the National Programme Audit scheme. A randomised 10% surveillance audit was undertaken by independent auditors. This was a centrally coordinated audit process. The results were held centrally, with feedback provided throughout the year to reporters to allow for reflection of practice.
- The time between when a referral to the service for a scan was received and that scan being booked was recorded. Between October 2017 and September 2018, 76% of patients were seen within five days. 10% of routine patients were seen within six days and 6% of patients were seen within seven days. 8% of routine patients were seen over seven days. Reasons for delays included scanner breakdown, administration processing error and problems getting radio-active isotope. All delays were investigated, none had resulted in serious incident notification needing to be raised and actions had been taken to ensure reduction of future delays were taken and lessons identified were learned.
- The service manager audited and compared key elements of the referral and scanning pathway and these were benchmarked with other AML locations. Maidstone PET-CT was in compliance.
- Audits of the quality of the images were carried out by the acute trust. The services re-scanning rate was negligible.
- The consultants from the acute trust were responsible for the reporting and analysis of images. This was monitored by the acute trust and the clinical commissioning group.
- There was an audit schedule in place. The audits aimed to assist in monitoring the service and drive improvement. They involved all staff ensuring they had ownership of things that had gone well and that needed to be improved. Audits included incidents, complaints, hand hygiene, infection prevention and control and patient satisfaction.

- The service submitted a monthly report to the commissioners. This provided the commissioners with information on activity and any issues impacting on service provision such, as staffing, equipment, operational issues and improvements. We saw no evidence of issues that could have a significant impact on the provision of services

Competent staff

- **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 within the organisation. Manufacturers provided equipment training.
- 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.
- All eligible staff had had their professional registration checked in the last 12 months.
- All radiographers were HCPC registered and met the standards to ensure delivery of safe and effective services to patients. Clinical staff were required to complete continued professional development (CPD) to meet their professional body requirements. All eligible staff had revalidated their professional registrations in a timely manner.
- Staff suitability key attributes were assessed as part of the interview process which were based on predetermined questioning that aligned with the service's core values. 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.
- Staff competence was managed through a performance review process. For example, where local audit, complaints and incidents highlighted potential failing areas different staff members were identified as needing specific support and development.

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- 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.
- There were clear records showing who was entitled to administer radioactive medicinal products (RMP) together with who has the necessary certificate from 'The Administration of Radioactive Substances Advisory Committee' (ARSAC).

Multidisciplinary working

- **Staff worked collaboratively across services to understand and meet people's needs.**
- Staff were appropriately involved in assessing, planning and delivering patient's care and treatment. Staff worked closely with the referring NHS trusts, ensuring a smooth pathway for patients. Staff were aware of the days of the different cancer multidisciplinary meetings ran and endeavoured to ensure the results of short notice scans were available to be discussed when necessary. Staff from the service would attend these meetings as appropriate.
- Staff working in the service had good relationships with external partners and undertook scans for local NHS providers. We saw good communication between services and there were opportunities for staff to contact referrers for advice and support.

Seven-day services

- The service was not open seven days a week. It operated from Monday to Friday. Monday, Wednesday and Thursday from 7:30am to 7:30pm and Tuesday and Friday from 8am to 6pm. To ensure sufficient capacity was available to enable patients to be scanned within the contracted time frame the unit was supported by a mobile PET-CT scanner twice a month when required.
- The service had capacity for 84 patient slots a week.

Health promotion

- **The service ensured that people received information about their care and support options relating to the service provided.**
- The service provided information leaflets such as understanding your PET-CT scan. These 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.

- We did not see any other health promotion information leaflets and posters on subjects such as smoking cessation services and information on living with cancer in the waiting rooms. We did not see a range of information leaflets for patients and relatives, usually available in services such as this one including those from Macmillan and the Stoke Association which patients could take away.

Consent and Mental Capacity Act

- **Staff judged whether people had capacity to make particular decisions whenever this was necessary. They involved relevant people and professionals when needed, and recorded their actions and assessments whenever this was proportionate and appropriate.**
- 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. They were familiar with processes such as best interest decisions.
- Staff told us if, for example, a patient with a learning disability or a person living with dementia was due to attend, they were advised to attend with a relative or carer to provide the necessary support. We were assured staff empowered such patients to make decisions in relation to their treatment. We also witnessed how they supported next of kin or carers during this process.
- Interventional procedures were consented for appropriately. A written corporate consent policy was available to staff and was written in line with national guidance. We reviewed four patient care records all included a consent to treatment record. An interventional procedure is defined as any procedure used for diagnosis or treatment that involves incision; puncture; entry into a body cavity; or the use of ionising, electromagnetic or acoustic energy.

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- We observed staff obtaining verbal consent from the patients during their interventions and asking if they were understood what was happening. Patients we spoke with confirmed their consent had been obtained several times throughout the scanning process.
- Scan safety consent forms were completed by all patients prior to their scan, to record the patients' consent. These also contained patient's answers to safety screening. Administration staff made themselves available to explain any questions patients may have relating to informed risks regarding the diagnostic screening procedure. This was in line with the Standards for Patient Consent Particular to Radiology, second edition, 2012: Patients are involved in decisions made about their care and information has been communicated effectively.

Are diagnostic imaging services caring?

Good 

We rated this service as **good**.

Compassionate care

- **People were treated with dignity, respect and kindness during all interactions with staff. Their relationships with staff were positive.**
- Staff took the time, where possible to interact with patient's and those close to them in a respectful and considerate manner. Staff were encouraging, sensitive and supportive to patients and those close to them. They understood and respected patient's personal, cultural, social and religious needs, and took these into account.
- Staff made sure that patients' privacy and dignity was respected, for example, blinds over the window between the control and scanning room were closed while the patient moved onto the scanning plinth. Staff also made patients aware of the close circuit television in the examination rooms so they did not change in these rooms.
- We heard examples of when staff had gone out of their way to support patients who were distressed or felt overwhelmed by their experience. Patient feedback from thank you cards demonstrated how staff were compassionate and caring in such situations.

- We spoke with four patients and one relative and all said they had been very happy with the service they had received. One patient described the service as efficient and caring. No patients raised any concerns about their treatment. All said they had been treated with care, compassion and respect. This met NICE QS15 Statement 2: 'Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills'.
- Every patient had the opportunity to complete the NHS Friends and Family Test (FFT) and indicate their likelihood to recommend the service. There was an opportunity to add free text comments on any positive or negative aspects. The FFT process used a paper-based form complete with website address so that patients may choose to complete it digitally on a personal device. The results were collated by an external provider and delivered to service managers. The service manager reviewed the results which summarised response rates for this location between October 2017 and September 2018. Overall likelihood to recommend was 94.8% and unlikely to recommend was 1.5%. 3.7% were neither likely or unlikely to recommend.
- The free text comments were interrogated to enable positive staff feedback and individuals could be praised where they noted for the quality of care delivered. Negative comments were scrutinised for opportunities to drive improvement in the service.

Emotional support

- **The service made sure that staff had the time, information and support they need to provide care and support in a compassionate and person centred way.**
- 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 attending the service were often feeling nervous and anxious. Staff provided reassurance and support and demonstrated a calm and reassuring approach. We heard examples when patients that required something to hold on too to help with their anxiety were allowed to take this into the examination room.
- Staff were supportive to patients who suffered from claustrophobia. Staff took the time to support patients emotionally as well as being by their side during

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practice runs. This allowed patients to experience what it was like to undergo the procedure. We heard examples of staff teaching patients to breath and supporting them emotionally during procedures.

- A patient described how when they told a member of staff how anxious they had been prior to attending. The member of staff had been spoken to them with compassion and had ensured that they had understood the information they required to lessen their concerns. This met NICE QS15 Statement 10: Patients have their physical and psychological needs regularly assessed and addressed.
- Staff told us, if a patient or family member became distressed, rather than provide support to them in an open environment, staff could take them in to a private room to talk to them to assist them to maintain their privacy and dignity.

Understanding and involvement of patients and those close to them

- **The service provided sufficient time for staff to develop trusting relationships with people, their families, friends and other carers. Staff noticed when people were in discomfort or distress and took swift action to provide care and support.**
- 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 explaining procedures and reassuring both patients and their families of the processes that occurred during their stay at the service. This met NICE QS15 statement 5: Patients are supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences.
- Staff made sure that patients and their relatives, could find further information or ask questions about their care and treatment. There were leaflets available about the scans offered.
- Relatives or carers were permitted to remain with the patient for their appointment if this was necessary. We saw how the service ensured patients felt comfortable and emotionally well by having their carers and partners with them. We also heard of an example where the

patients partner was invited to the control room to keep contact with the patient to decrease their fear and maintain them cooperative during the diagnostic procedure.

Are diagnostic imaging services responsive?

Good 

We rated this service as **good**

Service delivery to meet the needs of local people

- **People's needs were met through the way services were organised and delivered.**
- Information about the needs of the local population was used to inform how services were planned and delivered. The service provided PET-CT scanning through a national contract commissioned with NHS England as well as contracts with private referrers.
- Progress in delivering services against the contractual agreement was monitored by NHS England. Monitoring was reported through monthly contract review meetings with the acute trust, and measurement of quality outcomes for example, the patient experience. Service improvements were agreed at these regular meetings.
- The service was accessible, it was on an established bus route and there was accessible car parking.
- The facilities and premises were appropriate for the services that were planned and delivered. There was sufficient comfortable seating, disabled access toilets and coffee and tea services. Additional drinks and snacks were available in the attached main hospital building.
- Patients were provided with information in accessible formats before appointments. Appointment letters contained information required by the patient such as contact details, a map and directions and information about the intervention including any preparation such as fasting was required. The appointment letters were sent out, asked patients to call in if they had any queries or if they had answered yes to any of the questions on the safety questionnaire.
- All appointments were confirmed prior to patient's appointment, by phone. This helped reduce the number of do not attend (DNA's) and provided an opportunity

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for the patient to ask any questions they may have. Should a patient not be verbally contacted prior to their appointment, for example where a message had been left for the patient on an answer machine, the patient was asked to call the service to confirm their intention to attend the appointment. We were told that this process also facilitated the service's preparations should the person have any communications or disability needs and helped identify best ways to support patients' needs in cases of ill mental health. These notes were added to the patients file and were highlighted so that when the patient came through the door staff were aware of their needs.

- Staff were confident and competent assisting patients who required assistance with their mobility. We heard how patients who identified mobility concerns were provided with mobility chairs and the environment catered to people who were mobilised in beds from the hospital.
- Each examination room was assessed for suitability prior to its use and provided privacy and dignity. There was sufficient space in each examination room for individuals accompanying the patient, for example, relatives or carers as well as patients. The decoration of the rooms was calm and supported the activities being carried out in these rooms.

Meeting people's individual needs

- **People's needs were identified, including needs on the grounds of protected equality characteristics, and their choices and preferences and how these were met. These activities were regularly reviewed and drove service development.**
- 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. 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.
- The provider complied with the Accessible Information Standard by identifying, recording, flagging, sharing and meeting the information and communication needs of people with a disability or sensory loss. The main reception area had a low level reception desk and the facilities provided hearing loop technology.

- Reasonable adjustments were made so disabled patients could access and use services on an equal basis to others. All patients were encouraged in the appointment letter, to contact the unit if they had any needs, concerns or questions about their examination.
- The service had a system in place for managing the needs of patients living with dementia or learning disability. Staff making the referrals could add an alert which related to a patient's medical condition. Additionally, the environment in the examination rooms and PET-CT scanner was conducive to relaxation as there were environment lights and calm decoration. This was in line with NICE QS15 Statement 9: Patients experience care that is tailored to their needs and personal preferences, taking into account their circumstances, their ability to access services and their coexisting conditions.
- Patients had access to interpreters if the service was informed prior to the appointment. Staff also had access to language line, a phone translation service where appropriate. In a clinical emergency the service enabled staff to use a family member to translate at the radiographers' discretion.
- The unit had a patient trolley for patients who were transported to the unit from the nearby hospital or nearby trusts. The unit had been designed to meet the Disability Discrimination Act guidelines, with a dedicated uptake room, significantly bigger than the others, for bed-bounded patients. Additionally, a patslide and transfer board were available for patients requiring assistance transferring from their wheelchair or bed.
- We were told how AML provided support and training to clerical staff for advice with help in communicating with patients or if they had questions or concerns. Communication training was also offered to the clinical staff.
- Staff made patients comfortable with padding aids during the PET-CT scan. Patients were given 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 between the radiographer and the patient. Patients were also provided with eye masks should they feel claustrophobic.

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Access and flow

- **Patients had timely access to diagnostic imaging scanning.**
- Since opening in September 2017, the service had worked closely with the acute trust team to improve the quality of the service provided. The service could access a mobile service twice a week at the static centre, with the objective of reducing the turnaround times for patients. The unit had the potential to increase the capacity if required.
- Referral forms were received via the provider's NHS.net email, checked by the administrators to ensure that minimal data requirements were met, then input onto the AML RIS system ready for the booking process. Prior to contacting the patient, the referral form was reviewed by the bookings administrator to look for any specific requirements (e.g. a specific date for the scan defined by the Radiologist or referrer).
- Referrals were prioritised by clinical urgency. If patient symptoms were deemed to be clinically urgent, these patients were often given an appointment within two days depending on their urgency. However, slots were not held for clinically urgent referrals as they did not receive a significant number of these. Urgent referrals were offered on the first available appointment. There was an option for the patient to be scanned at Ashford PET-CT Centre if capacity at Maidstone was a problem.
- All patients on a two-week cancer pathway, were scanned within five days to enable swift report turnaround. Where several clinically urgent requests were received, advice was sought from a radiologist on the priority order for booking. The unit kept daily reserved slots to accommodate patients on this pathway. These slots could also be used to catch up with appointment times should any delays occur.
- Should the need arise to add an urgent referral into the waiting list when no appointments were available, the unit manager 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 them.
- The service identified that most procedures were PET-FDG scans. However, to facilitate ease of access,

improve radio-active tracer orders and improve patient access to PET-FEC scans there were strict appointment times for these scans with three available slots on both Tuesdays and Fridays.

- There were 18 planned procedures cancelled for non-clinical reasons between October 2017 and September 2018. The most frequent reason for cancellation was due to equipment failure, such as scanner break down.
- There were 18 planned procedures delayed for non-clinical reasons between October 2017 and September 2018. The most frequent reason for delay was due to machine breakdown or other equipment failure.
- 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.
- Reporting on scans was carried out by the trust radiologists. The service did not report on reporting times. However, staff told us urgent scans were reported on within 24 hours. This met national guidance.

Learning from complaints and concerns

- **The service used the learning from complaints and concerns as an opportunity for improvement. Staff could give examples of how they incorporated learning into daily practice.**
- Patients we spoke with told us they knew how to make a complaint or raise concerns about the service. Additionally, a patients' guide to making comments, compliments and concerns was available in the main waiting room. Staff would also provide these to patients upon request or when local staff recognised its need.
- AML had a management of concerns and complaints policy and procedure, all staff were obliged to acknowledge and comply with this process.
- The service received three complaints and four compliments between October 2017 and September 2018.
- All three complaints were managed under the formal complaints process. We saw evidence of learning and changes to the service following a complaint about waiting for administration staff to answer telephone calls. The service adjusted the administration rotas to be more responsive to the service's opening times.

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- The registered manager was responsible for overseeing the management of complaints at the service. We saw evidence in the team meeting minutes that learning from complaint investigations was discussed and recorded and learning was shared.

Are diagnostic imaging services well-led?

Good



We rated this service as **good**.

Leadership

- **Leaders had the skills, knowledge, experience and integrity to manage the service.**
- The service employed a part time, 0.5 whole time equivalent unit manager. The manager, who was also the registered manager for the location, also oversaw one other service, a diagnostic service based in Ashford and was available to support the unit at all times. They were supported by a regional head of PET-CT molecular imaging services.
- The manager was knowledgeable in leading the service. They had a clinical background which enabled them to understand the clinical aspect of the service as well as being familiarised with AML policies, procedures and governance. They understood the challenges to quality and sustainability the service faced and had pro-active ongoing action plans in place to address them.
- The registered manager was fully aware of the scope and limitations of the service, based on the size, numbers and type of staff, and type of work booked for. All staff told us leaders were keen to develop the service to ensure the patients received a quality service.
- Staff we spoke with found the registered manager to be approachable, supportive, and effective in their role.
- We saw there was effective succession planning that assured the continuity of services and sustained compassionate, inclusive and effective leadership. This was evident because on the first day of inspection the unit manager was away on training and the lead radiographer had taken leave. There was a clear identification of who was responsible for the service in their absence and how the service continued to operate in this case.

Vision and strategy

- **The provider had a clear vision and a set of values with quality and safety as their top priority.**
- The unit manager described how as an organisation, they had a primary responsibility towards the care of their patients and the provision of high quality sustainable services. This fit with the values of the service.
- The service values were those of AML:
- Collaboration: We work together and in partnership for all of our patients. We respect expertise and combine it to achieve more
- Excellence: We never compromise. We strive to deliver the very best in everything we do to ensure the highest quality of care. We treat our patients and each other with compassion, dignity and respect.
- Efficiency: Efficiency in healthcare means more patients get better care. We constantly seek new ways to use the scarce resource of healthcare more intelligently so that more people can live longer, fuller lives.
- Learning: Knowledge and understanding comes from learning. At Alliance Medical we are committed to ensuring that each and every one of us keeps on learning and that we continuously look for improved ways of working.
- Staff were aware and understood what the vision and values were and understood the strategy and their role in achieving it.
- Staff told us they were a major part in the way they worked. All staff were introduced to these core values at the corporate induction and then through their annual appraisal.
- The manager also identified the need to continue to grow the services they provided. We saw how the service had invested in their teams, infrastructure and approach to quality to ensure they could continue to deliver on their key quality goals: 'The provision of safe, effective and timely services; ensuring measured, responsible outcomes from our services and the provision of an experience that meets stakeholders' expectations.'
- Alliance Medical operated a collaborative approach to diagnostic imaging working with clinicians, local NHS providers and independent providers to keep the patient at the heart of their service. The collaborative approach to imaging services, aimed to future proof the service, provided access to emerging clinical and

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technological developments and supported research programmes, while supporting local pathways of care. The strategy was monitored through the clinical governance meeting and board meetings.

Culture

- **The service had a positive culture that was person-centred, open, inclusive and empowering. Leaders, managers and staff had a well-developed understanding of how they prioritised safe, high-quality, compassionate care.**
- The registered manager promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff we spoke with told us they felt well looked after and safe.
- The service's culture was centred on the needs and experience of patients. This attitude was clearly 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. Staff described the principles of duty of candour to us and were shown examples in team meetings where they would apply duty of candour. Staff were aware how they could raise concerns both informally and through the AML Freedom to Speak Up Guardian.
- 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.
- 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. The provider had produced a WRES report in 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.

Governance

- **There were governance frameworks to support the delivery of good quality care. 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 and action plans were identified on how to address things that 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 team meetings monthly. The manager would ensure necessary information was shared with staff if meetings were cancelled through email or through one to one meetings.
- Feedback and actions from performance discussion of local incidents were fed into processes at a corporate level. We saw evidence of this process in clinical governance committee meeting minutes and information governance and board risk 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. We saw examples of staff accountability through the action points identified in the monthly team meeting minutes.
- Working arrangements with partners and third-party providers were managed. For example, there was service level agreement between the service and the local acute trust. Monthly quality reports were issued and regular meetings were held with the radiology services manager at the acute trust to discuss the service provided.
- The registered manager was the governance and quality monitoring lead for the service.
- There were processes in place to ensure staff were fit for practice. For example, they were required to be competent and hold appropriate indemnity insurance in accordance with Health and Care Professions Council registration requirements.
- Staff working with radiation were provided with training in the regulations, radiation risks, and use of radiation such as the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R17) which had been introduced in February 2018.

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Managing risks, issues and performance

- **Management systems could identify and manage risks to the quality of the service. The service used the information to drive improvement within the service.**
- We saw evidence of a local risk assessment system in place with a process of escalation onto the corporate risk register. However, there was no ongoing local risk register. Monitoring of local risk was done based on the local risk assessment tool which was reviewed every two years. This tool was last reviewed in August 2017 and due for review in August 2019. This system could not assure adequate responsibility, accountability and an effective management of current risks at a local level.
- The service was responsive and conducted a thorough investigation of the two serious incidents and IR(ME)R reportable incident. We saw evidence of changes being made to practice which ensured the radiation risk assessment was reviewed and effective changes implemented to practice which lead to improved safety standards and practices.
- The registered manager and staff were all aware of patient risk related matters such as safeguarding, reporting of incidents, policies for safe practice and safe capacity. These documents were all readily available for consultation through the site file as well as through the AML intranet page.
- 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 and mandatory training levels were monitored.

Managing information

- **Electronic patient records were kept secure to prevent unauthorised access to data. Authorised staff demonstrated they could be easily accessed when required.**
- The service was aware of the requirements of managing a patient's personal information in accordance with relevant legislation and regulations. General Data Protection Regulations (GDPR) had been reviewed to

- ensure the service was operating within regulations. Staff viewed breaches of patient personal information as a serious incident and would therefore manage this as a serious incident and escalate to the appropriate bodies.
- We were assured that processes and policies used by the service correctly managed data and sustained data information to prevent breaches of data or information misuse. These processes also ensured that information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant. The service was supported by AML with management information analysts who were co-responsible for reviewing information when required.
 - Staff had access to AML policies and resource material through the internal computer system. This included training modules on information governance as well as access to policies such as the quality management framework policy and records management policy.
 - The registered manager knew and identified effective arrangements to ensure data and notifications were submitted to external bodies as required. For example, they explained how the Maidstone PET-CT Centre Service Agreement Dec 2016 highlighted the quality requirements and submission requests by NHS England.
 - There were sufficient computers available to enable staff to access the system when they needed to.

Engagement

- **The service involved people, their family, friends and other supporters in a meaningful way. Support and resources were available to enable staff to develop and be heard.**
- Patients' views and experiences were gathered and used to shape and improve the services and culture. Patient surveys were in use and the questions were sufficiently open ended to allow patients to express themselves. We saw changes were implemented following feedback from patients.
- There was regular engagement with commissioners to understand the service they required and how they could be improved. This produced an effective pathway for patients. The service had a good relationship with the local NHS trust.
- Employee engagement was measured through an annual employee survey which was conducted by an

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independent organisation to ensure confidentiality. In response to the survey, action plans were developed and progress against the plans was measured on a regular basis.

- We heard of a quarterly brief from the UK Managing Director One Team that was shared with the team. This allowed the opportunity for all staff to feedback areas they thought were important to them, to support the service.

Learning, continuous improvement and innovation

- **There was a strong focus on continuous learning at all levels of the organisation. Staff had objectives focused on improvement and learning. Leaders, managers and staff considered information about the service's performance and how it could be used to make improvements.**
- The team had monthly meetings to discuss governance requirements which apply to all units, including incidents, complaints, scan reports, health and safety issues, delivery against business plan, information governance issues, what went well and what didn't go so well. Issues relevant to the service were discussed and actioned as a team.
- Staff could use their appraisals to identify areas for innovation and training to improve practice. These improvements could be supported by data system review and processes for evaluating and sharing results of improvement work such as quality control checks and quality audits.
- Staff could provide examples of improvements and changes made to processes based on patient feedback, incidents and staff suggestion. For example, following an incident where a patient with recognised difficult veins, during the radio-active tracer administration their vein collapsed. Following investigation and advice sought, a new practice was introduced for patients with noted difficult veins or that had previous Radiotherapy and/or Chemotherapy. The administration of the radio-active tracer was done with a bolus as low as practicable to avoid venous collapse.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **SHOULD** take to improve

- The service should consider a strategy for local risk oversight that is reviewed regularly and assures adequate responsibility, accountability and an effective management of current risks at a local level.
- Staff should follow standard operating procedures such as the use of the occupied room warnings when patients were waiting prior to their scan.
- The service should provide information in key places such as the waiting area that offer patients advice and guidance through support groups and encourage healthy lifestyles.