

# The Thornbury Radiosurgery Centre Limited

## 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

Outstanding 

Are services safe?

Good 

Are services effective?

Outstanding 

Are services caring?

Outstanding 

Are services responsive?

Good 

Are services well-led?

Good 

### Overall summary

Thornbury Radiosurgery Centre Ltd Limited is an independent health care service providing stereotactic radiosurgery (SRS).

We inspected this service using our comprehensive inspection methodology. We carried out a short notice announced inspection on the 29 April 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.

# Summary of findings

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

Thornbury Radiosurgery Centre Limited was last inspected in 2016. We rated the service as requires improvement overall. We rated safe, responsive and well-led as requires improvement, and effective and caring as good. As part of this inspection we reviewed the actions we had told the service they needed to take to prevent any future breaches of regulation.

We found that the service had taken action to address all of the concerns from our last inspection.

We rated this service as **Outstanding** overall.

We found good practice in relation to:

- The service had enough staff with the right qualifications, skills, training and experience to provide the right care and treatment. All staff were up to date with mandatory training.
- The service had suitable premises and equipment, and this was well maintained.
- Staff had received training regarding safeguarding children and vulnerable adults, which included mental capacity and consent. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Patients were consented for treatment appropriately.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- Staffing was managed using professional judgment alongside daily and monthly planned patient activity.
- The service was planned and provided in a way that took account of patients and service users' views and feedback. The service monitored the effectiveness of their service and used the findings for improvement.
- Staff were competent, had clear objectives and received regular reviews and appraisals.
- Staff worked well together as a team and with service users, patients and suppliers to benefit patients and provide a good service.

- The centre met Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) safety requirements for staff skills and practice and for equipment.
- The service had suitable premises and equipment and looked after them well. We found the hospital was accessible to wheelchair users, with clear signage. Access to all areas was controlled using magnetic door locks and by use of reception areas staffed by administration staff.
- The environment was visibly clean, cleaning schedules were followed, and we observed staff following infection prevention and control practices. The service completed monthly infection control audits, results were collated and disseminated to the wider team.
- We observed that all staff were polite and courteous to patients from arriving at the department to when they left. Patients told us they were happy with the service and that they had been talked through what to expect at every stage of the process.
- Patients told us the service was easy to access. There was no waiting list for patients requiring treatment.
- An interpreter service was available for patients if required; health promotion leaflets were available for service users.
- The service had a vision for what it wanted to achieve and identified actions developed with the views of staff, patients and service users taken into consideration.
- The service had not received any complaints in the last 12 months and was responsive to patient feedback.
- The service had systems and processes in place to minimise risks and manage issues and performance.

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

- The provider should review the management surrounding the storage of medicines to ensure visibility and effective stock control.
- The provider should review the systems and processes surrounding the sharing of information with staff to ensure they are aware of company performance and updates.

**Ann Ford**

Deputy Chief Inspector of Hospitals (North Region)

# Summary of findings

## Our judgements about each of the main services

### Service

**Medical care  
(including  
older people's  
care)**

### Rating

**Outstanding**



### Summary of each main service

We rated this service as outstanding overall with ratings of outstanding for effective and caring and good for safe, responsive and well-led. There were areas of good practice and a small number of things the provider must do to improve. Details are at the end of the report.

# Summary of findings

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Outstanding



# Thornbury Radiosurgery Centre Limited

## Services we looked at

Medical care (including older people's care)

# Summary of this inspection

## Background to The Thornbury Radiosurgery Centre Limited

The Thornbury Radiosurgery Centre is located at a local private hospital in Sheffield and is a partnership with Medical Equipment Solutions Limited (MESL) providing a radiosurgery service treating brain tumours and other intracranial conditions. The service works in partnership with the local NHS Foundation Trust to provide treatment for NHS patients from all over the UK and offers a worldwide service for private patients. The host hospital provides various support services including diagnostic imaging under a service level agreement.

The centre is a sub-contractor to the local NHS Foundation Trust and treats tier one to four patients as a Supracentre. This means that the centre was awarded the NHS England contract to treat tier one to four patients for secondary brain and skull-based tumours (tiers 1 and 2) and also for rarer/complex clinical conditions including vascular and functional (tiers 3 and 4). Tier three and four

patients generally have more complex conditions and the NHS England service specification for this treatment sets out the precise requirements. The service is not contracted to treat children.

A total of 301 patients were treated from March 2018 to April 2019. Of these, 280 were NHS funded patients and 21 were self-funded.

This service's registered manager has been in post since December 2018. The registered manager has combined experience as a specialist stereotactic radiosurgery (SRS) treatment radiographer and is responsible for the day to day operations. The service is supported by management resources from MESL, the parent company. The clinical lead (also chair of the medical advisory committee leads the consultant team and is also clinical lead for the local NHS Foundation Trust.

## Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise in radiology. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

## Information about The Thornbury Radiosurgery Centre Limited

The service is registered with CQC to provide the following regulated activities

- Surgical procedures
- Treatment of disease, disorder or injury.

Thornbury Radiosurgery Centre is an independent healthcare service providing stereotactic radiosurgery (SRS). The centre opened in 2008 and is operated and managed by the Thornbury Radiosurgery Centre Ltd. The service is located at a local private hospital in Sheffield.

The centre is part of the Medical Equipment Solutions Group which also owns and operates a second SRS service in London providing the other NHS England SRS Centre of Excellence.

SRS is a method of treating selected tumours or lesions in the brain using a specialist Gamma Knife. This can include secondary brain tumours (metastases), other tumours (malignant and benign), vascular and functional. Procedures are completed as a day case although there are arrangements in place within the hosting hospital, for overnight stays before and after treatment on the ward.

There were five consultants granted practising privileges to practice in the service. A core team of six staff, one

# Summary of this inspection

registered manager, three full time therapy radiographers, one part time equivalent healthcare assistant and one part time equivalent administrative coordinator. The patient pathway was supported by additional radiographers and nursing staff via a service level agreement who were employed by the host hospital. There was also a team of neuro-radiologists and medical physicists available on treatment days.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced visit to the service on 29 April 2019.

## Activity

The service performed 301 radiosurgery treatments from March 2018 to April 2019, of these, 280 were NHS patients and 21 were private patients.

## Track record on safety

- Zero never events
- Zero deaths
- Zero serious incidents

- Ten clinical incidents from March 2018 to April 2019
- Zero incidences of healthcare acquired methicillin-resistant staphylococcus aureus (MRSA),
- Zero incidences of healthcare acquired methicillin-sensitive staphylococcus aureus (MSSA)
- Zero incidences of healthcare acquired clostridium difficile (C.diff)
- Zero incidences of healthcare acquired Escherichia coli E-Coli
- Zero complaints.

## Accreditation by a national body

- Quality management Systems ISO9001 accreditation (April 2019)

## Services provided for the clinic under service level agreement:

- IT and equipment maintenance, servicing and repair.

# 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?

Our rating of safe improved. We rated it as **Good** because:

- Since our last inspection the service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The service had enough staff with the right qualifications, skills, training and experience to provide the right care and treatment.
- The service had suitable premises and equipment, and these was well maintained. They used control measures to prevent the spread of infection.
- The centre met Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) safety requirements for staff skills and practice and for equipment.
- Staff had received training for safeguarding children and vulnerable adults. The service had a safeguarding adults' policy which was in date and in line with current best practice.
- Since our last inspection the service ensured all staff, including doctors with practising privileges, were checked by the Disclosure and Barring Service (DBS).
- Since our last inspection staff completed and updated risk assessments for each patient. They kept clear records of care provided.
- Since our last inspection. The service had improved incident reporting culture and awareness. Staff recognised incidents and knew how to report them. Managers investigated incidents and shared lessons learned with the whole team.
- The service had a system for receiving and cascading medical device alerts and patient safety alerts from the Central Alerting System to staff.

However:

- The provider should review the management surrounding the storage of medicines to ensure visibility and effective stock control.

Good



### Are services effective?

Our rating of effective improved. We rated it as **Outstanding** because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. All policies were in date, version controlled and had a named author.

Outstanding



# Summary of this inspection

- Since our last inspection the service ensured that they met the NHS England service specification for stereotactic radiosurgery for the additional standards for tier 3 and 4 conditions for a clinical oncologist to be part of the planning multidisciplinary team.
- The service made sure staff were competent for their roles. Managers appraised work performance and held supervision meetings with staff to provide support and monitor the effectiveness of the service.
- Staff worked well together as a team and with patients and suppliers to benefit patients and provide a good service.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them.
- Staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could update.
- The service routinely provided health promotion information for service users.
- The service undertook audits regarding patient outcomes such as image quality and appropriateness of referrals.

## Are services caring?

Our rating of caring improved. We rated it as **Outstanding** because:

- Staff cared for patients with compassion and respect. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Patients told us they were happy with the service and that they had been talked through what to expect at every stage of the process.
- There was a strong, visible person centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted peoples dignity.
- Staff explained what would happen in a way patients could understand and gave them the opportunity to ask questions.

**Outstanding**



## Are services responsive?

Our rating of responsive improved. We rated it as **Good** because:

**Good**



# Summary of this inspection

- The service was planned and provided in a way that took account of the patients and service users views and feedback.
- Patients told us the service was easy to access.
- There was no waiting list from March 2018 to April 2019.
- The service took account of patients' individual needs.
- The service had not received any complaints in the last 12 months and had treated any concerns received from feedback cards seriously. Concerns were shared with all staff and improvements made.
- The service provided pre-assessment of all patients undergoing radiosurgery. Since the last inspection at the pre-assessment stage, patients were asked if they required additional support such as interpreting services, sign language, disability access and transport/hotel accommodation.

## Are services well-led?

Our rating of well-led improved. We rated it as **Good** because:

- The service had managers with the right skills and abilities to run the service.
- The service had a vision for what it wanted to achieve and identified actions developed with the views of staff, patients and service users taken into consideration.
- Staff were supported, and managers and staff had a sense of common purpose and shared values.
- The service had an inclusive culture and staff wanted to continually improve the quality of its service.
- Since the last inspection the service ensured there was a robust process surrounding the management of staff competency checks including evidence of current professional registration, indemnity insurance, up-to-date appraisal and training and Disclosure and Barring Service checks (DBS).
- The service had systems and processes in place to minimise risks and manage issues and performance. Since our last inspection the service had reviewed and evidenced a robust reporting culture. The risk register highlighted when a risk had been identified and when it was last reviewed.
- Since the last inspection the service attended regular clinical governance meetings at the STHT site and monthly governance meetings with at the host hospital.
- The service engaged well with patients, staff, stakeholders and suppliers to plan and manage appropriate services.
- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

However:

**Good**



# Summary of this inspection

- Information was not shared with the wider team to ensure that staff were made aware of company performance and updates.

# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good	 Outstanding	 Outstanding	Good	Good	 Outstanding
Overall	Good	 Outstanding	 Outstanding	Good	Good	 Outstanding

# Medical care (including older people's care)

Safe	Good 
Effective	Outstanding 
Caring	Outstanding 
Responsive	Good 
Well-led	Good 

## Are medical care (including older people's care) safe?

Good 

Our rating of safe improved. We rated it as **good**.

### Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Training was provided by an NHS approved external training provider and staff told us they were up to date with their training and were given time to complete this. Mandatory training was off site and presented as a one-day face to face course. Training compliance was 100% for all staff and this was an improvement since the last inspection. We saw evidence of staff training records which were stored electronically for individual staff members.
- The service set a yearly target of 100% for completion of mandatory training. Mandatory training modules included equality & diversity, safeguarding adults and children, health and safety at work, control of substances hazardous to health, information governance, resuscitation, fire safety awareness, infection control, food hygiene, medicines administration, basic life support, safeguarding vulnerable adults (level 1 & 2), safeguarding children (level 1 & 2) manual handling, lone working and conflict resolution management.

- We saw that individual members of staff received an email, triggered from the system, if any required mandatory training was due for renewal. The service manager told us that there was a month's warning period for training renewal.
- Specific in-house training was also undertaken for fire, infection control and manual handling.
- Competencies and training were specified to meet with the requirements of the National Health Service Executive (NHSE), Ionising Radiation Medical Exposure Regulations (IRMER) and take into account the European Gamma Knife Society Guidelines.
- Senior management told us that strengthening induction, mandatory training and continual professional development was a quality objective for 2019 alongside closer integration with the local NHS trust.

### Safeguarding

- **Staff understood how to protect patients from abuse and when to contact other agencies to do so.**
- Staff had training on how to recognise and report abuse, and they knew how to apply this. No patients had been referred at the service within the last twelve months.
- CQC had received no reported safeguarding concerns in relation to the centre.
- The safeguarding lead for the centre was the registered manager of the service and was trained to level 3 in safeguarding adults. The service did not treat children. The service had arrangements to contact the host hospital safeguarding lead for advice and support. Learning was shared at regular staff meetings and at monthly clinical governance meetings.



# Medical care (including older people's care)

- The centre provided copies of policies and processes that were in place to safeguard vulnerable adults and young people which were in date, had a named author and were version controlled.
- Staff training records showed all operational staff were trained in safeguarding adults and children. Although the centre did not treat children, all staff were trained in safeguarding adults and children level two.
- Staff we spoke with were all aware of their responsibilities and could articulate what they would do if they had safeguarding concerns.
- Managers told us granting doctors practising privileges included checking safeguarding training compliance (completed as a requirement of their substantive post within the NHS) in their renewal applications. We saw evidence of compliance with safeguarding training in all five consultant's practising privileges files that we reviewed electronically.
- Managers told us that all staff, including doctors with practising privileges, were checked by the Disclosure and Barring Service (DBS). We saw evidence of compliance with DBS checks in all six consultant's practising privileges files that we reviewed electronically on the day of inspection. We saw evidence of consultant mandatory and safeguard training, this was an improvement since the last inspection.
- There was a service level agreement contract in place with the host hospital to keep the premises clean.
- We saw that staff ensured treatment rooms and equipment in all departments were cleaned regularly. Staff cleaned and decontaminated chairs and the therapy table with disinfectant wipes after each use. We saw checklists where staff had signed and dated every entry to show they had completed cleaning practices according to service policy and procedures.
- For patients needing cannulation for contrast injections, this was undertaken at point of admission by the registered medical officer. We observed staff performing cannulation used good aseptic technique and washing their hands correctly before and after the procedure. Patients' cannulas were removed in the hospital treatment room and disposed of correctly as clinical waste.
- The service had a service level agreement for the safe disposal of clinical waste with the host hospital. The general manager attended monthly clinical governance meetings and had gained assurance that the service level agreement was being met and that waste was being handled as per policy and procedure. Clinical waste posters were displayed in clinical areas highlighting the trust's coloured bag system for safe disposal.

## Cleanliness, infection control and hygiene

### • The service controlled infection risk well.

- Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The centre provided sufficient supplies of personal protective equipment (PPE) including disposable gloves and aprons. Staff disposed of used PPE safely and correctly. We saw PPE being worn when treating patients.
- We observed a consultant wearing a plastic apron and gloves when fitting head frames on patients prior to radiosurgery.
- The frame fitting procedure was undertaken using sterile instruments and appropriate aseptic (non-touch) technique.
- All patient areas at the centre including the consultation, preparation and treatment rooms were visibly clean and tidy.
- We saw that staff segregated and disposed of waste appropriately and they used sharps bins correctly.
- Training records showed radiosurgery staff received infection prevention and control training via mandatory training through an external company. Staff also attended yearly in-house training for infection control provided by the host hospital. Training records confirmed 100% compliance for radiosurgery staff.
- Staff at the centre told us that, as an outpatient procedure, patients attending for stereotactic radiosurgery were tested for signs of infection at the point of pre-assessment, one week prior to treatment and on the day of treatment.
- We reviewed the IPC audit undertaken in December 2018 which evidenced audit of hand hygiene, waste management, linen, sharps safety and environmental checks. The audit undertaken scored 100%. This was an improvement since the last inspection.
- We saw evidence of legionella test results from July 2018 which evidenced low trace elements in water samples of 3cfu/100mls (procedure room). Water



# Medical care (including older people's care)

sampling was managed by the host hospital as landlord for the centre. The results had been reviewed by a consultant microbiologist from the host hospital. Recommendations were to continue to flush water outlets daily for 3 minutes. We saw evidence of daily flush records during inspection. Water sample testing was rescheduled for re test in January 2019 which evidenced a result of 126cfu/100mls. Recommendations were to continue with daily flushing of water outlets.

## Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
  - The Gamma Knife equipment had been inspected by an external company as part of an annual audit process in October 2018.
  - The rooms in use to provide the service were suited to their purpose and comprised of a dedicated stereotactic radiosurgery (SRS) unit within the radiology department at the host hospital. The consulting and preparation areas, treatment room and administration areas were well equipped with everything staff needed to provide the service.
  - The environment was clean, light, spacious and accessible to people with a disability.
  - The centre did not have its own toilet facilities, but staff, patients, and visitors used those provided by the private hospital. These were single, disabled access toilets, and these areas were clean.
  - There were no radiological environmental hazards observed within the centre at the time of our inspection.
  - There were appropriate clinical and treatment rooms for storage and preparation of medicines, stock and for applying head frames to patients who were to undergo gamma knife surgery.
  - Staff told us they sent reusable equipment for decontamination off site under a service level agreement with a specialist company. Equipment was returned sterile and stored safely ready for use. There were sufficient sterile instruments available if additional kit was required. All sterile equipment was labelled as sterile and sealed appropriately. Traceability stickers were evident on sterile packs and then placed in patient notes following use to evidence tracking and traceability.
  - Staff told us resuscitation trolleys were available in the private hospital radiology and endoscopy departments.
- Staff told us these were managed, maintained, and checked by the private hospital. We observed the trollies during our inspection which were within easy reach of the centre, checks had been recorded, dated and initialled. Staff were aware of the hospital emergency number to dial in the event of a patient collapse.
- Equipment throughout the centre was calibrated and maintained within the manufacturer's timescales. We saw maintenance contracts and service level agreements for specialist equipment including the gamma knife. Following service and maintenance, engineers followed the controlled area and equipment handover protocol with the radiographer.
  - The design of the environment within the radiosurgery treatment area was appropriate. Waiting and clinical areas were clean. There were radiation warning signs at doors leading to the treatment area. Imaging treatment room 'no entry' signs were clearly visible and in use throughout the centre at the time of our inspection.
  - We saw, and staff confirmed, that there was enough equipment to meet the needs of patients within the centre. Staff told us they were confident to raise any immediate concerns to ensure they were rectified quickly or escalated to the department manager.
  - Staff in the centre demonstrated safe working methods to record patient doses for radiation.
  - We saw checklists and we observed staff carrying out quality assurance checks for all radiosurgery equipment. These were mandatory (must do) checks based on the Ionising Radiation Regulations 1999 and IR(ME)R 2000. The completion and compliance with IR(ME)R regulations ensured staff protected patients, themselves and other staff against unnecessary exposure to harmful radiation.
  - We saw centre policies and processes complied with guidance under IR(ME)R and the radiation regulations. An external radiation protection adviser audited compliance and reports we observed on site showed the centre met all IR(ME)R regulations. We saw the report following inspection in May 2018 which highlighted eight actions and recommendations. We saw evidence that these had been actioned.
  - The service did not have direct access for staff or consultants to the trust picture archiving system (PACS). Images were saved to encrypted compact discs for upload at Thornbury Radiosurgery Centre Limited. The



# Medical care (including older people's care)

service was working towards a virtual private network (VPN) system which would enable direct image exchange. Staff told us that the current system was safe and effective.

- The lead radiographer was the radiation protection supervisor and carried out risk assessments with ongoing safety indicators for all radiosurgery equipment and its use by staff. These were easily accessible to all centre staff.

## Assessing and responding to patient risk

### • Staff completed risk assessments for each patient.

- Staff told us, and we saw from patient records, that each individual case was discussed by the team prior to treatment. NHS and private patients were discussed in a multidisciplinary team (MDT) meeting held at the local NHS trust. All cases were also discussed in a planning meeting on the day of treatment, to identify risks and the best possible clinical and therapeutic approach to take. Records we saw included individualised care plans for all six patients reviewed and included completed NHS hospital pre-assessments.
- We followed the journey that patients had to take from the centre in the main hospital building to the separate MRI unit. This route was adjacent to the public car park and down a slight gradient. Patients fitted with a head frame were escorted in a wheelchair by a healthcare assistant and a radiographer. We were assured that the pathway was risk assessed on a daily basis pre-each treatment day. During inspection we saw that improvements had been made to the barriers which prevented cars parking on or near the pathway. Staff informed us, and we saw evidence, that each patient journey was recorded in individual patient pathways. The service had a policy in place, staff were aware of the importance of the need to provide an umbrella and blanket if necessary for the patient journey from the ward to the unit. Patients were made aware of the journey at the start of the treatment day and given the opportunity to ask questions. The service had also introduced a check list for staff to complete to record the patient journey and evidence explanation and discussion. This was an improvement since the last inspection.
- We observed the patient pathway through the MRI process. Patient identification risk checks were undertaken prior to gaining entry to the MRI scan room.

Renal function blood tests were checked and recorded in the patient pathway. Risk factors predisposing the patient to an adverse reaction to iodine contrast were checked pre-administration.

- We observed pause and check practice (right patient at the right time) undertaken for each patient treated according to the Society and College of radiographers (SCOR).
- During our inspection we observed admission and discharge of two patients who had received treatment. Patients were admitted by radiographers and a clinical assessment was undertaken and recorded. Safety checks were recorded re patient name, date of birth and specific allergies.
- Both patients were admitted to the day case rooms situated next door to the treatment rooms. We were told by staff that the centre had the option to admit patients directly onto the ward at the host hospital if they were treating more than two patients during the day or if patients required overnight facilities due to frailty or had to travel long distances. We observed a clinical handover sheet and a patient handover policy (TRCL SOP C209) for use by the hospital ward staff and TRCL staff when relocating patients from and to the ward and the centre. However, during our inspection the centre had not required the use of the ward setting.
- We saw that staff checked patients' identity before carrying out any discussion or intervention.
- We saw radiosurgery staff using a safety checklist as part of the procedure for readying patients for gamma knife surgery.
- We saw the consultant assess individual patient's risks before fitting the head frame and adjusted the placement of the frame accordingly.
- There was a consultant, medical physics expert and therapy radiographer present at all times during procedures.
- There were up to date policies and procedures in the imaging department to ensure that the risks to patients from exposure to harmful substances were managed and minimised.
- All patients were accompanied to and from the ward to the preparation room, MRI scanner, and radiosurgery procedure room.
- There were written procedures and local protocols and rules in place as required under the IR(ME)R regulations.



# Medical care (including older people's care)

- Staff used mobile dosimeters (small devices to measure radiation) in radiosurgery areas to ensure that any exposure to higher levels of radiation than was considered safe was identified and accurately recorded. The medical physics expert collected dosimeters and sent them for testing monthly. Findings were feedback to staff at monthly staff meetings
- The service had an external service level agreement with a radiation protection advisor (RPA) who was contracted to undertake annual audit. We reviewed the last inspection recommendations undertaken in May 2018. The RPA advisor had made eight recommendations and actions. All recommendations had been implemented.
- A radiation protection advisor could be contacted to give advice to staff when needed. Staff told us they were available to provide regular advice and support.
- Staff told us patients who had been identified as living alone would stay on the ward for the night following their treatment to ensure they could be observed and cared for, should they need additional support. The service had a service level agreement with the host hospital to care for patients overnight.
- In an emergency, staff explained that they could access medical support from the private hospital resident medical officer. Staff could organise a blue light ambulance to take patients to the local NHS trust if and when required.
- We were assured any patient information required for the next treatment day for staff awareness was written on a communication board so important information / handover information not lost. This board was not accessible to the public to ensure patient confidentiality.
- We observed the removal of a patient's cannula prior to discharge which was recorded in the patient pathway.
- The service had a resuscitation policy in conjunction with a service level agreement with the host hospitals for the provision of resuscitation services.

## Nurse staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- Within the centre there was a core team of five staff; three full time therapy radiographers including the registered manager, one 0.5 full time equivalent

healthcare assistant and 0.5 one full time equivalent administrative coordinator. The team could access additional radiographer support from the lead radiographer at the host hospital or therapy radiographer support from the sister radiosurgery centre in London. The service had a service level agreement with the host hospital and received assurance surrounding staff employed at this service that they had received annual appraisal, DBS checks, mandatory and safeguarding training. This was monitored by the registered manager of the service.

- Stereotactic radiosurgery guidance states that two trained IRMER operators must be present during stereotactic treatment. We observed two trained therapy radiographers and an IRMER trained neurosurgeon were both present throughout patient treatment on the day of inspection.
- There were enough staff to safely care for the patients in the centre.
- There were no staff posts vacant at the time of our inspection.
- No bank or agency staff were used in the period March 2018 to April 2019.
- There was no reported staff sickness in the period from April 2018 to March 2019. There had also been no staff turnover within this period.
- The centre told us that patient cases were reviewed at a multi-disciplinary meeting and at outpatients appointments. Prior to treatment all patients were clinically assessed by qualified staff at the local hospital trust. Staffing was then determined based on the planned number of patients attending the service. Staff told us if a patient required additional care, they would request additional resources from the private hospital or reduce the number of patients scheduled for treatment that day.

## Medical staffing

- The centre employed six consultants under practising privileges. One consultant, who treated patients regularly in his substantive NHS post, had seen ten patients from March 2018 to April 2019. The other five had seen between 76 and 96 patients in this period.
- All consultants had to meet the criteria set out in Thornbury Radiosurgery Centre's policy to be granted authorisation to undertake the care and treatment of



# Medical care (including older people's care)

patients in the centre. We saw evidence to support that all consultants met this requirement. All six consultants had substantive posts at the local NHS Foundation Trust.

- Consultants made themselves available for contact and support for 24 hours following each procedure.

The private hospital provided a registered medical officer (RMO) for 24-hour medical cover, should this be needed.

## Records

- **Staff kept detailed records of patients care and treatment.**
- Data we reviewed indicated that during the last 12 months, records had always been available when needed.
- We looked at six sets of paper records and saw that they were complete, with contemporaneous notes and all staff had clearly signed entries. Records clearly indicated who had undertaken procedures, who had assisted, and what equipment had been used.
- Electronic records were also complete and showed; imaging, the full treatment planning process, and treatment given to each patient on each occasion.
- The service had an internal audit schedule. We reviewed the last records audit undertaken in October 2018 which scored 97%, patient records were audited quarterly internally by TRCL. Audit results were shared with staff at regular staff meetings and also displayed on the communication whiteboard held within the centre.
- Staff explained that as part of the patient pathway, the referral forms requested all relevant information be provided prior to consultation. If this was not provided, the referrer would be contacted for the information and an appointment was not arranged until the information was received.
- At the time of our inspection, referrals for NHS patients were arranged by the local NHS trust. Patient notes and diagnostic imaging were securely transferred to the centre in advance of any appointment.
- Patient records were stored securely in paper and electronic formats. All patient information was stored on a secure network with limited and controlled access. The general manager was responsible for requesting access for new users.

- Follow up patient information was stored electronically, and NHS patient records were returned to the trust. The service had a policy in place for the management of patient records which was in date, version controlled and had a named author.

## Medicines

- **The service followed best practice when administering local anaesthetic for pain relief when fitting patient head frames.**
- We saw that medicines were stored safely and securely. Staff told us, and records showed, that the therapy radiographer checked drugs regularly and rotated stock appropriately. However, we observed a number of medicines stored alongside other stock items impacting on storage space which impeded visibility. There was an audit trail of what had been ordered and staff told us they had a good foresight of cases coming in and could order according to required need.
- Consultant neurosurgeons prescribed and administered local anaesthetic when fitting head frames. They prescribed and administered the drug for each individual patient.
- The local anaesthetic was stored in a lockable cupboard in the treatment room. Key storage and management was managed by the service radiographers. The cupboards were locked at the time of inspection. We checked that daily room temperatures were recorded on the days that treatment was provided.
- There were no controlled drugs kept on the premises.
- Records we looked at showed recording of known patient allergies.

## Incidents

- **The service managed patient safety incidents well.**
- Staff recognised incidents and knew how to report them. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The centre reported ten clinical and six non-clinical incidents from March 2018 to April 2019.
- The service did not report any deaths or serious injuries for patients in its care from March 2018 to April 2019.
- The service did not report any never events from March 2018 to April 2019. Never events are serious incidents



# Medical care (including older people's care)

that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

- Staff and managers could give examples of how practice had changed as a result of an incident.
- We saw good shared learning from a recent incident in April 2019. The MRI scanner had broken down the night before the next days planned treatment. This information was shared with the wider team. After liaising with the referring hospital, arrangements were made to continue the treatment day as planned, framing patients and transferring the patient to the local NHS hospital for the MRI scan to be completed. Patient transfer was arranged as per TRCL policy C203 (transferring patients between departments/wards). While the first patient was being transported to the local NHS hospital the MRI scanner at TRCL had been repaired and tested to be operational. This prevented the need to transfer the remaining patient out of the hospital. The patient transferred to the local NHS hospital underwent MRI scanning without incident and was escorted back to TRCL for treatment planning. Clear lines of communication and adherence to policy ensured safe effective practice continued.
- Radiotherapists were aware of Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) requirements and the need to report radiation incidents to care quality commission.
- There had been no reportable radiation incidents in the 12 months prior to our inspection.

## Are medical care (including older people's care) effective?

Outstanding



Our rating of effective improved. We rated it as **outstanding**.

### Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness.** Managers checked to make sure staff followed guidance.

- Thornbury Radiosurgery Centre provided evidence to show the centre met the NHS England service specification for stereotactic radiosurgery. The centre was also compliant with guidance from professional bodies, including The Royal College of Radiologists and the Society and College of Radiographers. The centre followed the Institute of Physics in Engineering Medicine 'Guidelines for the provision of a Physics Service for Radiosurgery' 2002.
- The service met the NHS England service specification for stereotactic radiosurgery for the additional standards for tier 3 and 4 conditions for a clinical oncologist to be part of the planning and treatment team. All patients discussed at both the neuro-oncology multi-disciplinary (MDT) and the STRS MDT who were considered to be suitable for and benefit from STRS treatment, were discussed fully with a neuro-clinical oncologist. We were assured by the local NHS foundation trust that the master service specification for SRS/SRT was being met in full. This was an improvement since the last inspection.
- Targeting accuracy for the gamma knife equipment had been audited and approved by NHS England. We saw that staff carried out daily and monthly quality assurance checks to ensure that the equipment was appropriately calibrated.
- A folder specifying the policies relating to the centre was kept on site. Staff explained that the full policies were accessible online via a secure server. Staff signed a log to confirm that they had read and interpreted the policies relating to the centre. This was up to date at the time of our inspection. Policies were reviewed by the registered manager in conjunction with the company board.
- The service was ISO9001 accredited and was last inspected in April 2019. The ISO9001 quality management system standard is designed to help organisations ensure that they meet the needs of customers and other stakeholders while meeting statutory and regulatory requirements related to a product or service.
- Double contrast was used to ensure the best demarcation of tumours for accuracy of planning and treatment.

### Nutrition and hydration



# Medical care (including older people's care)

- **Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other preferences.**
- Following patient feedback surrounding the availability of food and drink, the service had introduced tea and coffee making facilities and a range of snacks, biscuits and soft drinks to offer patients throughout the treatment day. The service had also introduced a pre-treatment telephone call made by staff to patients, informing them that food would be provided and that snacks would be available until the hospital kitchen was opened at 08.30 hours. Patients were also advised to eat breakfast prior to admission.
- Staff told us that patients undergoing lengthy treatment were offered breaks to allow them to have a light snack and a drink. Patients confirmed this, and we observed that they had been provided with a break in their treatment and offered light snacks and drinks.
- **Managers monitored the effectiveness of care and treatment and used the findings to improve them.**
- There had been no unplanned transfers to other hospitals or readmissions to the centre in the period March 2018 to April 2019.
- In the last 12 months, there were no relevant national audits for SRS.
- Senior management informed us that a national audit of SRS/SRT facilities was planned to be undertaken by NHS England in 2019 (as per the Radiotherapy Trials Quality Assurance audit last undertaken in 2016).
- Local external audits undertaken included the environment agency, counter terrorism security advisors, radiation protection advisors and ISO9001 accreditation. No significant issues were raised as part of the audits undertaken. However, a number of recommendations and actions were highlighted post the radiation protection audit undertaken in May 2018. The recommendations and actions had been reviewed in a timely manner and actioned as part of the ongoing quality management systems.

## Pain relief

- **Staff assessed and monitored patients regularly to see if they were uncomfortable or in pain.**
- Patients were injected with local anaesthetic at the site where the head frame for surgery was applied. Staff told us that this could be 'topped up' by the treating consultant if patients reported feeling any sensation.
- We observed patients undergoing local anaesthetic injections. We saw staff ask patients if they could feel any pain and we saw that they provided top up anaesthetic until the patients reported they were pain free.
- Other than injectable local anaesthetic, no other pain medication was stored within the centre. Staff told us that if patients did request further pain relief then they would contact the host hospital or the resident medical officer to request assistance.
- Staff demonstrated they were aware that patients may be in pain and they ensured the treatment caused as little discomfort as possible. Positioning aids were available if needed and staff checked on patients' comfort via the intercom during the scan sequences. We observed staff offering patients assurance during individual procedures.
- Information about people's care and treatment, and their outcomes, was collected and monitored and used to improve care. New and improved processes had been introduced, accelerated by the appointment of a clinical fellow from the local NHS trust, in preparation for the National Health Service England (NHSE) Stereotactic Radiosurgery (SRS) dashboard and national database, now expected during 2019.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. TRCL were registered with The Private Healthcare Information Network (PHIN). PHIN is the independent, government-mandated source of information about private healthcare, working to empower patients to make better-informed choices of care provider.
- The service had a clear process in place to manage patient outcomes post treatment. The referring host hospital managed clinical patient outcome data. The host hospital submitted patient outcomes on a quarterly basis which is an NHS England requirement. There was a section in patient discharge leaflets that clearly notified patients that a follow-up questionnaire would be sent out by the host hospital referrer

## Patient outcomes



# Medical care (including older people's care)

approximately 9 months post-treatment. The discharge summary from TRCL was dictated by the treating consultant on the day of treatment and included in the NHS patient notes returned to the host hospital. The host hospital incorporated this information into the patient monitoring process.

- Following MRI scan results, the treatment team – consultant neuro-surgeon, consultant neuro-radiologist, and medical physics expert – planned in detail the treatment to be carried out and the radiographer programmed coordinates into the radiosurgery device. We observed that the clinical team was available during the procedure, which included continuous monitoring of the positioning of the patient within the machine. The team repeated all checks post operatively to ensure procedures had been carried out appropriately, all areas identified for treatment had been treated, and patients were suitable for discharge.

## Competent staff

- **The service made sure staff were competent for their roles.**
- Staff had received training relevant to their role. We saw online training records that showed the required training and level of competence of different members of staff. Each staff member's role and operator level were clearly recorded on the system.
- Radiosurgery treatment was undertaken by suitably trained staff. The registered manager for imaging services also worked alongside staff.
- Staff were encouraged and given protected time to complete continuing and professional development. Staff told us that they were encouraged and given opportunity to attend professional symposiums and seminars.
- As part of ongoing continuing development radiographer staff were undertaking an accredited radiation protection supervisor course. The registered manager advised us that the radioactive sources required changing as the current sources had been in use over four years with a life expectancy of five years. This was in the initial planning stage as the service required an approximate four week close down for replacement.

- We saw documentation to show consultant neurosurgeons were registered IR(ME)R practitioners and radiographers and physicists were registered IR(ME)R operators.
- We found that there was a structured probationary period for new staff and for all staff there were ongoing annual appraisals and mid-year performance reviews. New staff received an induction with three and six month reviews. We looked at the records for two members of staff and found that reviews and appraisals had been undertaken and staff had clear objectives regarding performance and development for the coming year.
- Data provided by TRCL showed that 100% of staff employed for more than 12 months had received an annual appraisal in the last 12 months. The service had checked the professional registration status for each radiographer.
- Staff told us that training and development was supported by the registered manager, this ensured competence was maintained and registered professionals met re-validation / re-registration requirements.
- Reception staff were included in training which meant they had the relevant safety knowledge and understanding to enter the controlled areas if needed, for example to act as a chaperone.
- The team kept up to date with the latest literature and took part in international networks, conferences and webinars. Various retrospective academic papers had been published. The clinical team included the president of the British Radiosurgery and International Stereotactic Radiosurgery Society. Accuracy data was collated on the treatment planning system and reported upon by the Medical Physics Expert (MPE).

## Multidisciplinary working

- **Staff of different kinds worked together as a team to benefit patients.**
- The referral system operated by the centre ensured that patients were identified and discussed at relevant MDTs (for example, in a neuro-oncology MDT at the local trust) prior to any NHS referral being accepted. We saw evidence of documented MDT review in all the patient records that we reviewed.



# Medical care (including older people's care)

- Multidisciplinary planning meetings took place prior to treatment for all patients. All NHS patients, from anywhere in the UK were referred to and discussed at a local NHS Trust neurosurgery MDT and private patients were discussed in fortnightly meetings at the centre. Radiosurgery planning was carried out immediately before each treatment with an up to date MRI scan by a neuro-radiologist, medical physicist, neurosurgeon and radiographers.
- We saw that the team included, managers, radiographers, administration staff and support workers who all worked well together to provide a high-quality service to their patients.
- Members of the team communicated well with each other and gave examples of when they had liaised with referring clinicians and or the reporting consultants to address any queries or to provide or obtain any necessary information regarding the patient's pathway.
- We observed effective multidisciplinary involvement throughout the patient pathway. Staff worked well together and respected each other's skills and contribution to the patients' care and experience.
- The team worked closely and collaboratively with colleagues at the local NHS trust, a local sister radiosurgery centre, the host hospital and had found innovative and efficient ways to deliver care (e.g. transition to day care).
- We observed a multi-disciplinary team meeting whilst reviewing an MRI scan, which was managed well, and encouraged participation from everyone involved.
- NHS and private patients were consented to treatment prior to their day of treatment. This took place at the outpatient appointment at the referring NHS trust. Staff told us, and we observed, that the consultant neurosurgeon then had a further discussion with patients attending for treatment to confirm they understood the procedure.
- We reviewed six consent forms. These showed that consent had been taken at the patient's outpatient appointment. Records showed that treatment followed within one to three weeks of the original consent being taken.
- We observed radiography staff confirming with patients that consent had been signed and recorded. However, we observed that second stage consent on the original consent form was not signed or dated. TRCL consent policy (SOP C201) states that patients treated under contract were pre-consented by the local NHS trust and would not be consented again by TRCL for the procedure. The medical advisory committee lead neurosurgeon confirmed that consent is taken and checked in line with centre policy. The treatment is completed under local anaesthetic and patients undergoing treatment confirm and validate consent prior to treatment. Verbal consent was documented in the patient pathway at the time of the procedure.
- We reviewed a copy of the TRCL patient checklist which required staff to check patient consent forms signed in clinic alongside verbal and implied consent used on the day of treatment. Staff could explain the consent procedure. Patients were aware of what they were attending and gave verbal consent to proceed. All patients were asked for permission prior to any intervention such as applying / removing frame, positioning on bed, cannulation etc.
- Staff within the centre completed Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training as part of the adult safeguarding training module. This meant that staff would be able to identify and address the needs of patients attending with capacity issues. We observed and spoke with staff and they were able to identify additional needs of patients in these circumstances. Staff told us that at the point of pre assessment patient mental capacity was checked to ensure patients had capacity prior to any treatment date being confirmed.

## Seven-day services

- The centre was open Monday to Thursday. Staff explained that treatments usually began at 8am with treatment normally being completed by 5pm. Up to three patient treatments were completed per day.
- The centre's lead neurosurgeon consultants were available twenty-four hours a day to provide cover as required for any stereotactic radiosurgery emergencies or for patient queries.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff understood their roles and responsibilities under the Mental Capacity Act 2005.**



# Medical care (including older people's care)

## Are medical care (including older people's care) caring?

Outstanding



Our rating of caring improved. We rated it as **outstanding**.

### Compassionate care

- **Staff cared for patients with compassion.** Feedback from patients confirmed that staff treated them well and with kindness.
- We observed patients being treated with compassion, dignity and respect. Patients told us that staff spoke to them on an appropriate level and were caring.
- Patients told us they were happy with the service and that they had been talked through what to expect at every stage of the process.
- There was a strong, visible person centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted peoples dignity.
- We observed comment cards from patients which, without exception, gave positive descriptions of experience of care, dignity and respect from all staff in the centre.
- There were no direct NHS patient referrals into TRCL. All NHS patients were treated on-behalf of the local NHS Trust in line with the agreed contract, therefore patient feedback was collected by the trust, in accordance with their protocols.
- Returned surveys were reviewed immediately to ensure if there were specific areas that required action. Data was collated without delay and a quarterly report generated and analysed for trends and shared at team meetings and reviewed by the MAC and reported to the board of directors.
- The service had received 59 patient feedback responses from January to March 2019. Patients said the helpfulness of staff and quality of care was very good, or outstanding. 98.3% of patients said overall experience was very good or outstanding. 100% Patients said they were likely, or extremely likely to recommend the service to friends or family.
- The main key theme surrounding information collated was that all patients rated the staff 10/10 (outstanding) for helpfulness, and all participants said they would

recommend the service to friends or family without exception (all replied 10- extremely likely). All participants to date marked 'yes' to receiving a pre-treatment telephone call, that they were informed of the follow up procedure, had an information leaflet to take away, and that all questions were answered before they left.

### Emotional support

- **Staff provided emotional support to patients to minimise their distress.** Patients were provided with contact details for their key worker should they require any support or have any questions. Staff told us that key workers would often 'go the extra mile' to book accommodation or transport on behalf of patients.
- We saw that patient cases were followed by the same clinical team members; from the patient's arrival in the hospital, through their treatment and to discharge. Staff told us that this allowed for a strong rapport and understanding to develop with the patient and their family.
- Patients told us that staff were supportive and that they would feel comfortable seeking advice or guidance around their care.
- Staff told us it was common for patients to feel anxious or claustrophobic in the scanning area but that they usually managed to keep patients calm and able to complete the procedure by talking to them through the intercom, or by staying in the room and being visible if necessary.

### Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- Patients were given the opportunity to ask questions or to tell staff if there was anything they did not understand.
- Patients told us staff had explained safety precautions and that they understood possible issues and the reasons why they had to remove jewellery, piercings etc.
- Staff explained what was happening by communicating with patients throughout the treatment phase.



# Medical care (including older people's care)

- We saw staff going through safety checklists and contraindications with patients to ensure they understood what was to happen and that they were aware of any risks to safety.
- We saw staff ensuring patients understood discharge information and hospital contact details to seek further advice if required.

## Are medical care (including older people's care) responsive?

Good



Our rating of responsive improved. We rated it as **good**.

### Service delivery to meet the needs of local people

- **The service planned and provided services in a way that met the needs of local people.**
- For NHS patients, the centre worked closely with the local NHS trust to plan and deliver care to patients requiring surgery. This included a commitment to see a minimum number of patients per year.
- The centre was located within the private hospital. This provided adequate car parking and an on-site restaurant. There were also public transport routes providing patients with bus services that stopped directly outside of the private hospital grounds.
- The waiting area had comfortable seating for patients and the clinic was accessible to users of wheelchairs.
- We observed a consultant dictating discharge letters immediately following patients' treatment at the centre.
- All patients received an MRI scan the same day as their radiosurgery treatment to ensure up to date images were used for accurate interventions.
- Post discharge patients returned to the referring team for follow up every three, six, twelve and twenty-four months.

### Meeting people's individual needs

- **The service took account of patients' individual needs.**
- We observed the fitting of two head frames during the inspection. The procedure was well managed by the

MDT team. The consultant neurosurgeon fit the head frame with the assistance of two radiotherapists and a healthcare assistant. The team fully explained the procedure and what to expect at each stage.

- Following fitting of the head frame, the healthcare assistant and radiotherapist escorted the patient in a wheelchair to the MRI department. The MRI unit was situated in a separate building to the main site. We observed staff informing patients of the journey and asking if they would like a blanket or umbrella due to potential adverse weather conditions. We observed staff explaining the journey and process to the patient which involved being seen in public as the direct route to MRI was via main reception. There was a policy in place directing staff to explain the journey that patients would make. The service had also introduced a check list for staff to complete to record the patient journey and evidence explanation and discussion.
- The centre provided all patients with patient information booklets both prior to and post treatment. Patients told us that they had received booklets and confirmed that they found them useful. We reviewed the booklets and they contained relevant information about treatment, as well as advice, Wi-Fi code and contact numbers should patients require any further assistance post treatment and discharge.
- At the pre-assessment stage the needs of patients with a disability were assessed and prioritised for treatment at the main hospital site if deemed appropriate.
- Face to face interpretation services were available and could be booked in advance of consultations or surgery. Staff told us that all patients were pre-assessed at the main hospital site. At this point patients were asked if they required interpretation services which could be provided if required. The service provided a welcome pack to all patients which incorporated patient flash cards covering essential topics for use throughout the patient journey. Staff told us that patient feedback had prompted them to introduce the flash cards which patients found useful.
- Staff told us that patients were routinely offered the opportunity to stay in the private hospital the night following their treatment. Staff explained that this was stressed as an option to patients who may be returning home alone or who may be at risk of complications to ensure that they were provided with appropriate care following treatment. Overnight stays prior to and



# Medical care (including older people's care)

following treatments were included in the cost of treatments for NHS and private patients, so patients were never asked to pay for their stay. In addition, staff told us that overnight hotel accommodation was offered for patients as an alternative option who lived a long distance from the centre due to the early morning admission for patients. Patient feedback was positive surrounding this service.

## Access and flow

- **People could access the service when they needed it.** The centre had cancelled no patient procedures for non-clinical reasons in the 12 months prior to our inspection.
- The centre reported no breaches against the NHS 18 week waiting time standard in the period March 2018 to April 2019. Staff confirmed that the centre routinely met a two week target for all patients with cerebral metastases.
- Data provided by the service during the inspection showed that the average waiting time for private patients from March 2018 to April 2019 was 13 weeks. Staff explained that waiting times were impacted on by patient choice as to when they wanted to receive surgery.
- We observed a patient being discharged from the centre. They were provided with appropriate information about their follow up care and contact details for how to contact the service.
- The centre told us they had no patients that did not attend for treatment. The centre would occasionally be asked to rearrange surgery by patients in advance but, to the knowledge of management staff, no patient had ever failed to attend for surgery.

## Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**
- The centre had not received any complaints between April 2018 and March 2019. The service had a complaints policy which was in date, version controlled and had a named author.
- The centre staff told us they had reviewed the complaints procedure since the last inspection.
- All patients received a complaint leaflet at point of discharge. We also observed complaint leaflets readily

available in patient treatment areas. The guidance advised patients to complain in person whilst at the centre as a local resolution (stage one). Patients could also complain via the chief executive (stage two) or complain via an independent external adjudication (stage three).

- Management staff explained that any complaints directed to the NHS regarding NHS patients would be discussed at a project board meeting with the local NHS trust. No complaint had been received or raised about the centre at these meetings.

## Are medical care (including older people's care) well-led?

Good



Our rating of well-led improved. We rated it as **good**.

## Leadership

- **Managers had the right skills and abilities to run the service providing high-quality sustainable care.** The service was led by the chief executive officer and managed by the registered manager who was responsible for the day to day running of the unit.
- The registered manager had combined experience as a specialist stereotactic radiosurgery (SRS) treatment radiographer and was responsible for the day to day operations. The service is supported by management resources from Medical Equipment Solutions Limited (MESL), the parent company. The clinical lead (also chair of the medical advisory committee (MAC) leads the consultant team and is also clinical lead for STHT.
- The registered manager had worked for TRCL for nine years and was well respected by staff. A number of actions had been addressed since they were appointed as manager. We saw examples of proactive and supportive leadership. We observed a multi-disciplinary team meeting whilst reviewing an MRI scan, which was managed well, and encouraged participation from everyone involved
- Staff said they felt supported and that the leaders were approachable, they gave examples of being supported with training and development and told us that their ideas were listened to and acted upon in discussion with the team.



# Medical care (including older people's care)

- The service offered staff induction, training, appraisals and peer review and were strengthening support to staff to maintain and further develop their professional skills as a key quality objective for 2019.
- The manager explained that consultants holding practising privileges must also be registered as independent data controllers with the Information Commissioner's Office to ensure any patient identifiable information removed from the hospital premises was secure at all times.

## Vision and strategy

- **The service had a vision for what it wanted to achieve and workable plans to turn it into action.**
- The centre's vision was; 'to provide a service which puts the patient first, providing exceptional patient care and experience, working to make stereotactic radiosurgery accessible to all that can benefit'.
- Staff we spoke with were aware of the centre's vision and strategic direction and this was included in the centre's induction for new members of staff.
- During our inspection we saw and heard that staff and managers understood and upheld the values of the service.
- The service's strategy was focused on building partnerships to enable data and information to be shared and training to be offered, building external relationships, and ensuring financial stability. This strategy was shared with its partner organisation, the local NHS Trust and was aligned with the new NHS England service specification for stereotactic surgery.
- The registered manager told us feedback from users of the service had been considered as had staff views when developing the strategy.
- We reviewed the business plan from March 2019 which evidenced a clear strategy for 2019/20.

## Culture

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- Staff spoke positively about the leadership within the centre. Staff told us that they felt supported by management and were confident to raise any concerns.

- Staff told us that the team within the centre worked well together. We observed a friendly culture with staff interacting with colleagues and patients in a polite and professional manner.
- Policies and procedures were in place to guide staff practice and expected behaviours. Policies indicated that any issues, where staff acted outside of policy or displayed inappropriate behaviours, would be taken seriously and dealt with appropriately.
- Staff told us they felt listened to, supported and that training and development was encouraged.
- All staff we spoke with were passionate about delivering excellence and ensuring the patient were at the very heart of the service.
- We saw that communication between managers and staff was open and honest. Problems and concerns were discussed, and all staff had a proactive approach to finding practical solutions.

## Governance

- **The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.**
- There was a clear governance structure where the director of the service held a quarterly review meeting with the registered manager to discuss service performance. We reviewed the last quarterly report October to December 2018. The report evidenced discussion surrounding: policies and procedure, risk management, incidents, complaints, quality dashboard, compliance, audit and medical advisory committee meetings. The outcomes of the meeting were shared with all staff at monthly staff meetings.
- Staff told us that the service manager held regular monthly staff meetings which included discussion surrounding: incidents, risk register, training, infection control, medication/stock control and any other business.
- We reviewed minutes from medical advisory committee meeting minutes (January 2019). The minutes had a set agenda including, apologies, confirmation of previous minutes, progress report, risks, incidents, complaints, patient feedback, day case evaluation, treatment prescription, dose and range and any other business.



# Medical care (including older people's care)

- There was a robust process surrounding the management of staff competency checks including evidence of current professional registration, indemnity insurance, up-to-date appraisal and training and Disclosure and Barring Service checks (DBS). Practising privileges were reviewed in-line with the relevant TRCL policy which was in date, a named author and version controlled. TRCL had access granted by all six consultants to access individual L2P accounts. The L2P system was an appraisal and revalidation software tool for the healthcare sector. We saw evidence of all six consultants training, appraisal and revalidation, consultant professional registration with the General Medical Council (GMC), indemnity insurance and DBS checks. This was an improvement since the last inspection.
- We reviewed the TRCL quality account for 2019 which highlighted key priorities moving forward. These included, clinical effectiveness, patient experience and investing in staff.
- The service had undergone a comprehensive ISO9001 accreditation process in March 2019 and was accredited in April 2019 with quality management systems and a systematic and integrated approach to monitoring, reviewing and determining quality objectives.
- We reviewed management board meeting minutes (January 2019) which were held quarterly and chaired by a consultant radiologist. The management board had oversight of all the activity at the site. The director's report included; how the facility was performing and what issues and challenges it faced. We saw that health and safety; finance and sustainability, patient feedback and activity were standard agenda items and there was a solution focussed approach to any issues raised. There was an annual planning process in place and any business development proposals would also be taken to these meetings for discussion and approval. However, information was not shared with the wider team to ensure that staff were made aware of company performance and updates.
- There were good systems and processes in place for maintenance of equipment and there were appropriate policies, local rules and protocols in place
- There was oversight of staff training, competence and that relevant staff had current professional registration.
- We saw good shared learning from incidents.
- The service had monthly team meetings We saw minutes and the action log that indicated incidents, patient feedback, changes to service delivery, or any other issues that needed addressing were discussed in this meeting. Staff felt these meetings were valuable for team work, to enable staff to contribute their ideas, to discuss training needs and to ensure smooth running of the service.

## Managing risks, issues and performance

- **The service identified risks well, planned to eliminate or reduce them, and cope with both the expected and unexpected, there was a framework to support this to help with consistent management, documentation of mitigations and easy oversight and review.**
- Service-specific risks were recorded in a risk register. We reviewed the risk register, risks were categorised and rated red, amber, or green according to their impact and likelihood. Mitigating actions and controls were identified and each risk was assigned a responsible person. The risk register had been amended following the last inspection to highlight when a risk had been identified and when it was last reviewed. This was an improvement since the last inspection
- The risk register was split into differing sections covering patient pathway, clinical, operational performance, governance and human resource. The risk register was reported quarterly to the company board as part of a detailed governance report and discussed and reviewed as a standard agenda item.
- The service attended regular clinical governance meetings at the local NHS trust and monthly governance meetings with the host hospital. This was an improvement since the last inspection.
- The service had indemnity and insurance in place and was able to provide evidence of this.
- The service had business continuity plans and a backup server for patient records and image systems.
- All staff we spoke with told us that quality and safety were of a high priority. Managers had oversight of staff



# Medical care (including older people's care)

training, competency and performance. Disclosure and Barring Service (DBS) checks had been completed and recorded in line with service policy. This was an improvement since the last inspection

- The service had a programme of audits in place, undertaken monthly. The registered manager had oversight of audit activity and discussed results in monthly staff meetings.
- The Medical Equipment Solutions Limited board met quarterly. The board comprised of a national representative from the host hospital, MESL directors (clinical and non-clinical), a legal advisor, and a finance manager.
- We reviewed three sets of minutes of board meetings, from August 2018 to January 2019. The minutes included reference to discussion of financial risks, patient activity, governance and quality reports, complaints, incident reports, risk register, staffing, and concerns arising from the medical advisory committee. This was an improvement since the last inspection.

## Managing information

- **The service collected, analysed, managed and used information well to support its activities, using secure electronic systems with security safeguards.**
- All staff had undergone information governance training and we saw that the recent changes to General Data Protection Regulation (GDPR) had been considered and discussed at board level (April 2018).
- There were systems and processes in place to maintain security of information including patient records.
- The service had an information governance policy in place regarding confidential and secure processing of sensitive information. Records and care plans were stored safely and appropriately.
- Level of access to IT systems and patient information was role specific and each member of staff had an individual log in.
- Following the introduction of the General Data Protection Regulation and new Data Protection Act, new or updated policies had been implemented for information governance, data protection and data privacy policy. Awareness training of GDPR was provided to staff in addition to their mandatory information

governance training. TRCL provided the local NHS trust with full details of treatment provided updating patient notes which were transferred by secure protocols. Completeness of the information was internally audited and reviewed by the local NHS trust with no issues having been highlighted or reported during 2018.

## Engagement

- **The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.**
- Staff told us that, as a small team, staff engagement was informal. This included regular feedback on the progress and achievements of the centre. Staff told us that they were also kept informed and involved in service developments.
- Staff told us that they felt engaged by leaders. This had included being able to offer opinion and input into proposed new models of delivering care.
- The service had developed a joint service improvement plan with its partner organisation the local NHS Trust to deliver the new NHS England service specification for stereotactic radiosurgery.
- Historically, feedback was collected via a postal questionnaire which was sent out a few days post treatment. This however, only had an estimated 30% response rate. A newer in-house feedback tool was adopted in the form of an electronic tablet in February 2018. A process was devised to maximise the data capture and responses. The service had commenced collating patient feedback via an electronic tablet. Response rate was variable. Following staff review the consensus was that the questions were too long and did not flow chronologically. The service changed the feedback format from electronic tablets to paper based in October 2018. Feedback collated was reviewed each quarter. In February 2019 the service reverted to paper questionnaires with a positive increase in patient response and the quality of feedback.

## Learning, continuous improvement and innovation

- **The service was committed to improving services.**
- The service had introduced a simplified reporting process since the last inspection. The registered manager held monthly meetings with the host hospital governance officer and the host hospital executive



## Medical care (including older people's care)

director. Monthly meetings were held with the registered manager and the Thornbury radiosurgery centre chief executive officer along with monthly meetings with the local NHS trust.

- We saw good shared learning from a recent incident in April 2019. The MRI scanner had broken down the night before the next day's planned treatment. This information was shared with the wider team. After liaising with the referring hospital, arrangements were made to continue the treatment day as planned, framing patients and transferring the patient to the local NHS trust for the MRI scan to be completed. Patient

transfer was arranged as per TRCL policy C203 (transferring patients between departments/wards). Whilst the first patient was being transported to the local trust the MRI scanner at TRCL had been repaired and tested to be operational. This prevented the need to transfer the remaining patient out of the hospital. The patient transferred to the local NHS trust underwent MRI scanning without incident and was escorted back to TRCL for treatment planning. Clear lines of communication and adherence to policy ensured safe effective practice continued.

# Outstanding practice and areas for improvement

## Outstanding practice

We found the caring and effective domains to be outstanding;

People were truly respected and valued as individuals and were empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.

Peoples needs were assessed and care and treatment delivered in line with current legislation, standards and evidenced based guidance to achieve effective outcomes.

## Areas for improvement

### Action the provider SHOULD take to improve

- The provider should review the management surrounding the storage of medicines to ensure visibility and effective stock control.
- The provider should review the systems and processes surrounding the dissemination of company information to ensure that staff are made aware of company performance and updates.