Source Bioscience UK Limited

Source Bioscience UK Limited

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

Source Bioscience UK Ltd is a private company offering a medical laboratory service. It provides diagnostic testing and information and services, to enable healthcare professionals make appropriate decisions about treatment options for people. The service has a broad laboratory service offering for genomic research, healthcare diagnostics and precision medicine innovations.

Clients include both NHS providers and the private sector.

We inspected this service but did not rate it as CQC do not yet have the legal power to rate pathology services.

We did not rate this service. We found:

- The service had enough staff to provide the right level of service. The service controlled infection risk well. Staff assessed risks, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and had access to good information. Key services were available 5 days a week.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They understood the importance of the work they did and the impact on patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with local health care providers to plan and manage services and all staff were committed to improving services continually.

However:

- Not all staff had completed mandatory training.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical laboratories	Inspected but not rated	

Summary of findings

Contents

Summary of this inspection

Background to Source Bioscience UK Limited

Source Bioscience UK Ltd is a private company offering a medical laboratory service. It provides diagnostic testing and information and services, to enable healthcare professionals make appropriate decisions about treatment options for people. The service has a broad laboratory service offering for genomic research, healthcare diagnostics and precision medicine innovations.

Clients include both NHS providers and the pprivate sector. It is accredited to ISO 15189:2012 medical laboratories and listed on the United Kingdom Accreditation Service (UKAS)Schedule of Accreditation.

Source BioScience UK Ltd is a large diagnostic laboratory in Nottingham. The laboratory does not have any direct contact with patients. Therefore, the building is inaccessible to the public with only staff and authorised visitors are permitted to enter. All services are conducted on site including: sample cutting and slide preparation, digital pathology, diagnostics, quality assessment, administrative work, finance, commercial and marketing and IT. Samples are received from NHS hospitals and independent hospitals and services. Approximately 150 individuals work on site.

There were two laboratories. A cellular pathology laboratory, primarily preparing tissue samples for the subsequent diagnosis of diseases such as cancer. There was also a laboratory suited to test for infectious diseases such as Covid-19. This was used during the pandemic but was currently being used for other activity. They also provide a digital pathology service whereby hospitals send digital images of sample (slides) to the service instead of physical slides for analysis by the consultant pathologists and their teams.

The provider had recently acquired an additional site in Chichester (LD Pathology) and had incorporated the site into their business continuity plan. Some of their senior staff worked across both sites.

The service was established in 2011 and there was a registered manager in post.

The service was regulated to provide the following regulated activity;

- Diagnostic and screening services.

How we carried out this inspection

We carried out an unannounced inspection on 14th November 2023 using our comprehensive inspection methodology.

We spoke with 15 staff including scientists and scientist assistants, managers, leaders, administration and human resources staff. We also observed activity and processes carried out within the laboratories and looked at policies and other documents including recruitment information.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Summary of this inspection

Outstanding practice

We found the following outstanding practice:

- The service were innovative in their work with digital pathology and were recognised for their achievements in May 2023 when they won an award for the 'Best Hospital Technology Implementation' by an independent organisation. This radically lowered their cancer diagnostic reporting times from over two weeks to under three days. The awarding organisation described the achievement as 'transformative for the NHS workforce, as well as the patients awaiting diagnostic testing'.

Areas for improvement

Action the service SHOULD take to improve:

- The service should ensure that they comply with their own training target for mandatory training modules.
- The service should ensure they identify ways to improve the response rate of feedback from referring organisations.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical laboratories	Inspected but not rated	Inspected but not rated	Not inspected	Inspected but not rated	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Not inspected	Inspected but not rated	Inspected but not rated	Inspected but not rated

Inspected but not rated

Medical laboratories

Safe	Inspected but not rated
Effective	Inspected but not rated
Responsive	Inspected but not rated
Well-led	Inspected but not rated

Is the service safe?

Inspected but not rated

Mandatory training

The service provided mandatory training in key skills to all staff and but not all staff were up to date with this.

All staff received mandatory training and updated this annually. Staff completed training modules tailored to their role including health and safety, Control of Substances Hazardous to Health (COSHH), risk assessments, manual handling, and infection prevention and control.

The mandatory training was comprehensive and met the needs of service users and staff. Managers monitored mandatory training and reported compliance to senior leaders in the monthly quality assurance meetings.

Mandatory training compliance was 83% against a service target of 95% at the time we inspected. Figures included staff from both sites. Managers told us that low compliance was due to having a large intake of new recruits at their buddy site who were still in training.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect themselves from infection and prevent cross contamination of specimens. They kept equipment and the premises visibly clean.

The laboratory areas and equipment were visibly clean and well-maintained. The laboratories and other areas were cleaned daily by an external company.

Staff followed infection control principles, they took action to prevent cross contamination including the use of personal protective equipment and undertook cleaning of equipment between each case. They also completed a full clean down of the laboratories at the end of each day.

Staff were familiar with the policies and protocols and how to access them. These included policies and protocols to minimise or prevent the risk of Hepatitis, HIV, COVID and accidental sharps injury.

Inspected but not rated

Medical laboratories

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment. Staff managed clinical waste well.

The design of the environment and facilities followed national guidance, such as the Department of Health; Health Building Note 15 Facilities for pathology services guidance. This included the laboratory size, clinical hand washing facilities, eye wash facilities, first aid box, laboratory coat peg area, kitchen facilities, staff changing areas, and a standardized information technology system. The office and administration areas were separate to the laboratory areas. All areas were accessible only by secure key entry and not accessible to the public.

An onsite estates manager oversaw the management and maintenance of the environment, facilities and all equipment. The service had enough suitable equipment; there was also spare equipment to ensure there was no disruption in the service. There were regular checks of equipment and systematic recording of maintenance. Staff knew who to go to if they encountered any problems and knew how to report an issue. Staff carried out daily safety checks of specialist laboratory equipment. All reagents and chemicals seen were in date and stored safely in the appropriate cupboards.

Staff stored and disposed of specimens and clinical waste safely. There were contract arrangements in place to safely manage waste and clinical specimens. Clinical waste was collected by an external company weekly. Clinical and domestic waste bins were available, and waste was handled appropriately with separate colour-coded arrangements for general waste, clinical waste and sharps.

Assessing and responding to patient risk

Staff prioritised results where patients needed urgent medical attention and made sure they provided these to the referring clinician within agreed timescales.

Staff completed and updated risk assessments to remove or minimise risks. There were up to date risk assessments and risk management plans for various sample testing, equipment and chemicals used in the service and these were reviewed regularly.

There was a process in place to identify and act on urgent requests, and there were escalation protocols for unexpected or abnormal results that required immediate or urgent medical intervention. Abnormal or unexpected results that required attention were highlighted to the referring clinicians through the pathology report.

The service had a system in place for appropriately trained consultant pathologists to respond to requests for clinical advice in a timely manner. This was in line with the Key Performance Indicators for pathology services.

Laboratory results were available in a timely manner for clinical decision-making and the turnaround time for results was monitored by managers. For complex cases such as where further test investigations, or a second opinion was needed, the turnaround times were agreed with the referrer.

Staffing

The service had enough laboratory staff with the right qualifications, skills, training and experience to provide the right level of service. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave staff a full induction.

Inspected but not rated

Medical laboratories

There were 120 staff working for the service including laboratory staff, managers, pathologists and other roles. These included human resources, finance, information technology, marketing, and education. There was also a range of trainee staff, administration staff, educators, managers, quality assurance staff, and support staff in a variety of roles.

The laboratory manager and biomedical scientists were registered with the Health and Care Professions Council. The senior clinical staffing consisted of a clinical director who was a consultant pathologist, a second consultant pathologist who worked mainly with digital pathology and 228 pathologists [GR9] working under practising privileges in the service. These staff were responsible for the analysis of samples and providing clinical interpretation or advice. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent healthcare service. The clinical directors were responsible for granting practicing privileges.

The medical director was available on site 2 days each week to analyse samples and provide clinical advice. Staff had access to consultants who worked remotely for analysis of samples.

The service had low vacancy rates. At the time of our inspection there were 2 vacancy posts for biomedical laboratory scientists, and 6 vacancies for non-qualified staff, which the service were recruiting to. The service provided education and training for non-qualified staff to follow a career pathway to become a biomedical scientist. The service had low turnover rates, Managers told us that staff mainly left the service, once trained, to gain experience in the NHS.

Records

Staff kept detailed records of patients' specimens. Records were clear, up-to-date, stored securely and easily available to all staff.

Patients' laboratory results were clearly written and staff could access them easily.

All staff had access to an electronic records system they could update, ensuring information was available on the system in a timely manner. There was also a system in place to ensure any specimen requests included enough information before tests were carried out. This included three patient identifiers and other additional requirements such as the type of sample, clinical history and the date and time of the specimen collection. This was in line with the Health and Safety Executive's requirement in relation to the provision of enough information on specimen request forms in clinical diagnostic laboratories. When urgent samples were received, an urgent stamp was used to identify the specimen sample and record.

Records were stored securely in line with the Data Protection Act 2018, General Data Protection Regulation policy and RCPath (2015) guidance on storage and retention of pathological records and specimens. The electronic records were only accessible to authorised staff via a password protected system.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions from safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The service had a policy covering the reporting and investigation of incidents. If a sample was compromised, contaminated or had missing information, staff told us they would complete an incident form to report it as a non-conformance and contact the referring clinician.

Inspected but not rated

Medical laboratories

For the period of December 2022 to September 2023, the service reported there had been 7 incidents and 140 non-conformances reported. These related to issues such as; finding less pieces of tissue in the sample than the referral form stated; acetate stamp being removed in error; and sample being returned to client with part missing.

Incidents were reviewed by managers and included comprehensive investigations and action plans. Learning was shared, and where relevant, changes were made to systems and processes to avoid the same thing happening again.

We reviewed 5 incidents and found they were investigated and any changes made were shared with staff.

Safety alerts were shared with staff at weekly huddles, team meetings, by email and in the monthly newsletter. Managers ensured any actions were taken where required and that all staff were aware of any changes to practice.

Staff demonstrated an understanding of duty of candour and its impact on their practice. 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. This means providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.

Is the service effective?

Inspected but not rated

We did not rate this service.

Evidence-based care and treatment

The service followed national guidance when presenting and interpreting results. Managers made sure staff followed quality control procedures.

Staff followed up-to-date policies to plan and deliver a high-quality service in line with best practice and national guidance. The service had a range of policies, protocols and standard operating procedures (SOP) to support the delivery of services. We reviewed a sample of the policies and protocols and found they were all version controlled, reviewed by the provider and contained references to national guidance and best practice documents such as Royal College Pathologists and National Institute for Health and Care Excellence.

The service used the national guidelines for all of the procedures involved in preparing samples for testing. Managers and staff carried out a programme of regular audits of tests and quality assurance of presentation and interpretation of laboratory results. All reported results were subjected to a peer review for 2% of results, whereby the sample was sent to a second pathologist for checking. Any discrepancy in reported findings was discussed with clinicians.

The programme also included the calibration of measuring systems and verification which ensured results were traceable. The results of these audits were used to identify areas for improvement and compliance with national guidance and best practice. We looked at 3 recent audits that had been conducted for record keeping, DNA extraction and equipment maintenance and saw that no issues had been identified with practice. Audits showed they were compliant with national standards.

The service also used an inter-laboratory comparisons company as an alternative scheme for measure quality and consistency.

Patient outcomes

Staff monitored the effectiveness of their service. They used the findings to make improvements and achieved good outcomes. The service used quality assurance schemes to monitor and check their results. The service had ISO151819 accreditation.

The service participated in relevant clinical and external audits, including repeated audits. Outcomes of audits seen were positive, consistent and met expectations, such as national standards. There was a dedicated quality assurance manager who ensured compliance with external auditors and facilitated internal quality assurance audits and activities. Managers and staff used the results to improve service delivery. The service had key assurance indicators for timeliness of reports and clinical advice, which were monitored and discussed at governance meetings and the monthly business unit meeting.

The service had been accredited for proficiency by Genomics Quality Assessment (GenQA) which is an External Quality Assessment (EQA)/Proficiency Testing provider. They had also been accredited by United Kingdom National Quality Assurance Services (UKNEQAS) who are a service which provides quality assurance for services to check their clinical laboratory test results are accurate, reliable and comparable.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge. The laboratory staff had appropriate education, training and we saw evidence of continuous practice development in the staff records reviewed. Managers provided all new staff with an induction tailored to their role before they started work. Full funding was provided for external courses and continuous educational support was provided internally by a clinical educator.

Staff spoke extremely highly of the clinical educators and support and mentorship provided by the service.

There was a system in place for the support and supervision of all clinical and scientific staff in the service. For example, through induction, appraisals, training, observation of practice and competency assessments.

Consultants received clinical support and advice by attending regular multi-disciplinary team meetings within the NHS where clinical advice was provided, and interpretation of results were discussed.

Managers supported staff to develop through yearly appraisal, peer review of results and cases and constructive appraisals of their work and training needs. Managers identified any training needs their staff had during appraisals and gave them the time and opportunity to develop their skills and knowledge.

Staff also told us they had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. For example, a biomedical scientist had been seconded to a project, and staff were fully funded to attend external training to upskill and gain additional clinical qualifications. Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Inspected but not rated

Medical laboratories

Multidisciplinary working

Staff worked with other providers' teams to benefit patients. They supported each other to provide a good service.

The clinical directors attended regular multi-disciplinary (MDT) meetings for different specialities at different NHS and independent health care hospitals. These meetings included other professionals such as medical consultants, nurses, doctors, radiologists and occupational therapists. They used these meetings to access peer review, learning and clinical support.

Seven-day services

Services were available to support timely care.

The main services were provided 5 days each week 8am to 7pm

Is the service responsive?

Inspected but not rated

We did not rate this service.

Service planning and delivery to meet the needs of the local people

Managers planned and provided services in a way that met the needs of patients seen within the wider NHS and private healthcare systems.

The service worked with local NHS and independent hospitals to provide immunohistochemical and fluorescence in situ hybridisation testing of samples, preparation of samples for testing, and analysing samples.

Recent innovations had enabled samples to be shared with pathologists digitally for analysis which had reduced the time taken for some samples to be reported on and referring clinicians to be able to treat their patients.

Access and flow

Referring clinicians could access the service when they needed it and received timely results.

Managers monitored turnaround times and made sure referring clinicians could access services when needed and received their laboratory results within agreed timeframes and national targets. There was a system in place to ensure urgent samples were prioritised during the day to ensure patients received appropriate treatment in a timely manner.

The service's turnaround target times from specimen receipt to availability of authorised results was 7 days. This was in line with the Royal College of Pathologists (RCPath) histology turnaround times and reporting. The RcPath national turnaround times guidelines are for 80% of diagnostic results to be available within seven days and 90% within 10 calendar days. Managers told us they consistently met this target. We reviewed data reported in their monthly management review meeting notes and saw that, in the last 10 months audited, they had achieved this within 7 days for 6 out of 10 months and turnaround time was within 10 days for 9 out of the 10 months. There was 1 month where the average turnaround time was 10.8 days.

Inspected but not rated

Medical laboratories

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included the person who made the complaint in the investigation.

There had been 19 complaints received by the service in the last 12 months. However, staff had received training on managing complaints and understood the policy on complaints.

The service had recorded all instances where a referring clinician had called about a minor dissatisfaction or with queries about results. We reviewed 2 instances where a client had called about a delay in receiving a sample, and found an investigation had taken place and that actions were taken to resolve the issue.

Is the service well-led?

Inspected but not rated

We did not rate this service.

Leadership

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

There was a management structure in place with clear lines of responsibility and accountability; senior staff and department leads reported to the registered manager. Laboratory managers were responsible for the overall management of the laboratory and laboratory staff. Other managers had responsibilities for the management of the office staff and administrative tasks.

The registered manager and senior onsite staff reported to the executive team who in turn reported to the Chairman and Chief Executive Officer (CEO) of Source BioScience.

Staff told us onsite managers and visiting leaders were approachable and visible.

We observed positive working relationships between staff. Staff also told us they supported each other.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders monitored progress.

The service's strategy focused on staff training and development, expansion of the service, and the use of digital technology. The strategy and plans were discussed at senior team meetings.

Staff understood that the service was expanding and described shared values as 'putting the patient first' and 'working well together as a team. However, they could not verbalise a set of agreed values. Staff had not been involved in the development of a set of values or the mission statement. This was shared with the provider who took immediate action to rectify this. Roadshows and presentations were implemented in order to ensure staff awareness.

Staff told us they were encouraged to share ideas and that this included ideas about how the service could be improved and future development.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where staff could raise concerns without fear.

The service's culture encouraged openness and honesty. Staff felt they could raise concerns without fear and felt proud to work in the service. Staff enjoyed working for the service and many had worked there for many years. Managers encouraged participation in charity work and supported social events for staff.

Managers supported staff to develop through regular appraisals of their work and external training such as audit training, management training, role specific training and access to recognised qualifications.

Staff told us they enjoyed working in a friendly, supportive environment and participated in social events together. We observed staff of all grades working together in a friendly, supportive manner.

Governance

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

There was a robust governance structure within the service with a dedicated meeting structure and lines of accountability.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. There was a structured approach to the running and safety of the laboratory.

The service gained assurance through various governance meetings such as: annual management review meetings; monthly quality assurance meetings; monthly business unit meetings; laboratory staff meetings and team meetings.

We reviewed the minutes of various governance meetings and noted they were well attended and covered topics such as incidents, risks, training, audits, staff suggestions, service user feedback, quality management system, appraisal, staff recruitment, incidents and health and safety.

The service had processes and systems in place for the traceability of records and the retention and storage of pathological specimens which ensured a robust audit trail was maintained. This was in line with the national guidance on retention and storage of pathological specimens, and national guidance on record retention.

Inspected but not rated

Medical laboratories

The service operated an operational quality management system which was aligned to the United Kingdom Accreditation Service (UKAS) ISO 15189. (A UKAS accredited laboratory is able to demonstrate a full audit trail for tests). This included information management, equipment, record management, personnel management, facilities and safety management, audits and process control of specimen samples. The certificate of accreditation had been awarded in 2022.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Staff knew how to escalate risks to the managers. Staff were trained in the use of the service's risk register. The risk register included risks such as security, specimen loss from transport, fire alarm, electricity, equipment, regulatory compliance and staffing. We saw the risk register was reviewed regularly and included a description of each risk, severity, risk recurring, possible impact and mitigating actions. Managers shared information with staff in meetings and huddles.

The service was accredited by the United Kingdom Accreditation Service (UKAS) for each test carried out.

UKAS accreditation provides assurance in the quality of medical laboratories through a process that verifies their integrity, impartiality and competence. Assessments under UKAS accreditation ensure labs meet the relevant requirements including the operation of a quality management system and the ability to demonstrate that specific activities are performed within the criteria set out in the relevant standard.

The service had adequate facilities equipment and reagents needed to deliver the service and cope with any viral outbreak.

The health, safety and facilities manager oversaw the reviewing and updating of all risk assessments.

There was a contingency plan in place in the event of a system failure or continuing service disruption, staff were aware of this.

Information Management

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

There was a system in place to ensure the security of confidential patient data. The electronic record systems were password protected. Referring clinicians could access authorised reports of patients on the service portal following the completion of the registration process. This ensured only an authorised person could access patient confidential data. Pathologists working remotely could only access the information and records assigned to them for reporting on.

There was a policy to ensure compliance with the Data Protection Act 2018 and a General Data Protection Regulation policy. Staff had completed training on information governance and data security which covered their roles and responsibilities in relation to handling data and patient information.

There were systems in place to ensure the information used to monitor, manage and report on quality and performance were accurate, valid, reliable and timely.

The service had implemented a digital pathology service whereby digital images of samples and slides were sent to pathologists to review instead of physical samples. The service had enabled a faster and safer service and avoided the potential loss of samples in transit.

Engagement

Leaders actively and openly engaged with staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service engaged with staff through emails, weekly huddles and regular staff meetings. Staff were able to give feedback about the service through the staff suggestion box or share their ideas privately or during staff meetings. Staff told us they were able to resolve any issues and share ideas at any time with their managers.

Although staff understood what the service aimed to achieve, they had not been involved in developing the service's strategy or any agreed values for the service. This was brought to the attention of the registered manager who told us this was already being discussed with staff.

The service sought user feedback through an annual survey sent to external partners such as: clinics, GP practices, hospitals, individual consultants and health care providers. However, the response rate for the September 2022 survey was just 3%. The service was rated as 3 stars and 100% of respondents said they were either 'extremely satisfied' or 'satisfied' with the quality of the clinical reports they received.

Learning, continuous improvement and innovation

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

There was a culture of improvement and progress embedded in the service by the management team to meet the referring clinicians needs and to ensure the laboratory had up to date technology to aid staff and ensure their safety.

Managers told us the service was committed to training and learning, and that they were proud of their achievements in training biomedical scientists. External courses were fully funded by the provider.

Staff were encouraged to participate in secondments in new roles and projects.

The service were innovative in their work with digital pathology and had been recognised for their achievements in May 2023 when they won an award for the 'Best Hospital Technology implementation' by an independent market intelligence organisation.

The digital pathology has radically lowered their cancer diagnostic reporting times from over two weeks to under three days. The awarding organisation described the achievement as 'transformative for the NHS workforce, as well as the patients awaiting diagnostic testing'.

The service was also one of the first providers in the country to set up a covid-19 testing laboratory during the pandemic.