

QSRC Limited

The Gamma Knife Centre at The National Hospital for Neurology and Neurosurgery

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		Good	
Are services safe?		Good	
Are services effective?		Good	
Are services caring?		Good	
Are services responsive to people's needs?		Good	
Are services well-led?		Good	

Summary of findings

Overall summary

Our rating of this location improved. We rated it as good because

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk and managed medicines well. Staff assessed risks to patients and kept good care records.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service

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

Rating

Good



Summary of each main service

Medical care was the only care this service delivers. The service treated lesions or abnormalities in the brain, both benign and malignant using highly precise radiation and a technique called stereotactic radiosurgery (SRS). Although the technique is called radiosurgery it is not considered surgery it is only the radiation that enters the brain; most patients do not require general anaesthesia for this treatment. The service was one of two in England to be contracted by NHS England to treat all four tiers of SRS, this means they took referrals for patients from the whole of the South of England for some, more complex, treatments. We rated this service as good because it was safe, effective, caring, responsive and well led.

Summary of findings

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Summary of this inspection

Background to The Gamma Knife Centre at The National Hospital for Neurology and Neurosurgery

The Gamma Knife Centre at the National Hospital for Neurology and Neurosurgery is operated by QSRC Limited. They are an independent health care provider and work in partnership with the NHS trust they are based within, referred here on as the 'host NHS trust'.

The service provides care to both independently funded patients and NHS patients. They deliver stereotactic radiosurgery (SRS) to treat lesions in the brain. SRS is a very targeted way of delivery radiotherapy to precisely treat lesions. They treat malignant lesions, metastases, benign conditions and vascular conditions. The majority of patients are treated as outpatients, the service had an agreement with the host trust that they cared for the few patients who needed to be admitted to the ward for inpatient care.

The service was contracted by NHS England as one of two specialist SRS providers in England to provide gamma knife treatment to all diagnoses. Due to the specialist nature of the care delivered, NHS England has a four-tier system for complexity of patients, this provider was contracted to deliver care to all four tiers of patients.

The service provided care for patients from London and the South of England. They received referrals from external centres for specialist consideration.

At the time of inspection the service had two registered managers, this was because they did not work full time and this solution provided full time cover.

Due to the nature of the care delivered they had continued to treat patients throughout the COVID-19 pandemic, although numbers were reduced. In the past year the service had treated 334 patients.

The service was previously inspected in 2016 and was rated requires improvement overall and inadequate in well led. We followed up on these concerns with this inspection. On this inspection we found these had been addressed with significant improvements made which are reported in more detail in the following report.

How we carried out this inspection

We inspected this service using our comprehensive methodology. We carried out the unannounced inspection on 27 April and 30 April 2021. We used the cancer services methodology for inspection and have reported this under the medical care core service. The inspection team comprised of one acute hospital inspector and one Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspector and was overseen by Nicola Wise – Head of Hospitals for London. IR(ME)R is a regulation specifically to regulate the safe use of radiation for medical use.

To get to the heart of patient's experiences of care and treatment we ask the same five questions of all services: are they safe, effective, caring, responsive and well-led?

We spoke with 11 members of staff including administrative staff, radiographers, managers, neurosurgeons and physicists. We also spoke with two patients and reviewed two patient records.

Summary of this inspection

Outstanding practice

We found the following outstanding practice:

- The service had set up a multidisciplinary meeting across the South of England to support referring hospitals to identify and complete referrals for specific patient groups that had been identified as having complex referral pathways.
- The service was funding multiple research proposals to improve treatments and outcomes for future patients.
- The service provided patients with taxi transfers from home to the centre, for their treatment, so they could travel safely and not have to worry about how they would get to the service.
- The service offered counselling free of charge for all patients to support their mental wellbeing as well as treating their physical conditions and free access to a wellbeing smartphone application specifically designed to support patients with a cancer diagnoses.

Areas for improvement

Action a service **SHOULD** take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service **SHOULD take to improve:**

We told the service that it should take action because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall.

- The service should ensure it refers to the most recent IR(ME)R regulations in all its policies and protocols.
- The service should have more explicit protocols for caring for patients with suspected sepsis.






Our findings

Overview of ratings

Our ratings for this location are:

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

Medical care (Including older people's care)

Safe	Good 
Effective	Good 
Caring	Good 
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 because:

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. Managers showed us staff training records. All staff were 100% compliant with all mandatory training with the exception of manual handling practical training. Two members of staff were out of date for this training, we were told this was due to the COVID-19 pandemic meaning face to face training had been limited. One member of staff had booked to attend this training shortly after the inspection dates and the other member of staff was still trying to find a time to attend. Managers told us they were aware of the staff members who were not compliant with their training and these staff were always supported with manual handling of patients for patient and staff safety.

The mandatory training was comprehensive and met the needs of patients and staff. Clinical staff told us they were happy with the knowledge base the mandatory training gave them. They felt it was useful to have most of the training online as it meant they could fit it around their clinical duties.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. All staff, both clinical and nonclinical, were trained to the right level of safeguarding for both children and adults, this training was all in date. We were told the safeguarding training was delivered by the host NHS trust. This meant staff had access to the NHS trust's safeguarding team, if required.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010.

Medical care (Including older people's care)

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. All staff we spoke with were able to tell us signs that would cause them to be concerned about a patient and would lead them to raise a safeguarding referral.

Staff knew how to make a safeguarding referral, if one was needed, and who to inform if they had concerns. All staff we spoke with knew who their safeguarding lead. One radiographer showed us a safeguarding algorithm displayed on the notice board to remind staff how to make safeguarding referrals if one was needed.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were visibly clean and had suitable furnishings which were clean and well-maintained; all furnishings were able to be wiped clean, following patient use.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning services were provided by the host NHS trust, under a service level agreement. We saw a cleaning rota on the wall that specified what needed to be cleaned, and how often. This was signed to demonstrate cleaning had been completed. Managers told us they were able to access further cleaning if it was needed. We were told recently there had been a patient who was positive for COVID-19 who had needed treatment. This treatment could not be delayed as it could impact on the patient's outcome. Following the treatment, the cleaning team were contacted and completed an additional deep clean of all areas the patient had been in.

Staff followed infection control principles including the use of personal protective equipment (PPE). All staff who had contact with patients were observed to follow bare below the elbow principles and were wearing the right PPE at all times. Staff also followed infection prevention and control (IPC) principles when speaking with each other. The service had a policy describing the use of PPE for patients who were known to be COVID-19 positive to keep staff safe.

The service carried out monthly infection control audits to ensure all IPC principles were being followed. We saw the results for the most recent audit carried out and the service was following all their own guidelines. We also observed this to be true while on inspection.

Managers told us that during the COVID-19 pandemic they had followed the guidance provided by the host NHS trust and made it appropriate for their environment and patients. We saw their specific COVID-19 policies and they were in line with current government guidelines and had been regularly reviewed and amended throughout the past year. There were specific guidelines written for PPE, the patient pathway amendments, how to treat patients who had tested positive for COVID-19 and when to isolate and test. Due to the nature of some of the patients the service treated they could not ask all patients to wait ten days before having treatment if they tested positive and had clear pathways for treating those patients.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw "I am clean" stickers on equipment to demonstrate to the next user that it had been cleaned. We also observed staff cleaning everything a patient had touched, after they had finished using it, such as wheelchairs.

Medical care (Including older people's care)

For the treatment the service used metal frames which were gently screwed into a patient's head to hold them in one position. As this broke the skin the frames were fully decontaminated between each use. The service had a service level agreement with the host NHS trust for this to be carried out. We were told the sterilisation was always done quickly and efficiently, but if the service needed to they could request it was completed within 24 hours.

The service had no reported infections following treatment.

Environment and equipment

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

Patients could reach call bells. During our inspection we did not observe the call bells being used, but staff regularly checked in with patients throughout the day.

The design of the environment followed national guidance. The service had one treatment room which housed the gamma knife machine. This machine had live radiation sources in and there was appropriate radiation protection to keep staff and patients safe. When the machine was not in use the shutters on it were closed and this kept the room safe. To ensure the shutters were effective the room had two Geiger counters always switched on to monitor radiation levels, these would alert staff if there was a higher than expected level of radiation in the room and the machine had not secured the radioactive sources. Geiger counters are a machine which measures radiation levels. In addition to this the service also locked and alarmed their workspace when they were not working there, this meant if anybody attempted to access the room they would be detected. The alarm system was regularly tested and serviced.

Staff always wore personal dosimeters to monitor their radiation dose. If a member of staff had received a higher than expected dose of radiation this would be investigated.

Staff carried out daily safety checks of specialist equipment. The gamma knife treatment machine was checked every day it was used clinically. We saw records of the checks that were carried out, these records showed that this was complied with 100% of the time. In addition to the daily checks the physics team carried out more comprehensive checks every month and the machine manufacturer fully serviced the machine twice a year.

The daily safety checks included checking the output of the radioactive sources, this was then used to support the planning of treatments. As the machine used live radiation sources these had a useful lifespan and their radioactive output decreased with time. This increased the time it took to deliver treatments. The output of the radioactive sources was checked each day, and this was included in the planning process and used to calculate how long treatments would take to deliver.

The service had access to any manual handling equipment they needed under a service level agreement with the host NHS. Staff we spoke with told us where they would go to get manual handling equipment, such as hoists.

Staff disposed of clinical waste safely. All bins were colour coded and labelled to ensure the right waste was put in the right bin, we observed bins were used correctly. We also saw sharps bins were correctly put together and labelled with the date they were started. The service had a service level agreement with the host NHS trust for waste disposal.

Medical care (Including older people's care)

The radioactive sources in the gamma knife machine required changing at regular intervals as the dose rate dropped after a number of years and meant treatments took too long. The service had a contract with the machine manufacturer to remove and dispose of the old sources properly. When the sources were changed the service was sent a letter from the manufacturer to confirm that the sources were disposed of correctly, this is regulated by the Environment Agency.

Staff had access to a resuscitation trolley. This was owned by the host NHS trust and made available under a service level agreement to the service. All staff were aware where their nearest resuscitation trolley was. As this trolley was owned and maintained by the host NHS trust the service was not responsible for regularly checking the trolley.

All patients needed an MRI scan on the morning of treatment after the frame had been fitted, before treatment could be planned. The service had a service level agreement with the host NHS trust to allow them slots on the MRI scanners. MRI scanners use large magnets to acquire their scans, as such not all equipment is safe to be in an MRI scanner. The service used MRI safe equipment for anything that needed to go to the MRI scanner.

Assessing and responding to patient risk

Staff assessed the risk for each patient and monitored them throughout their treatment. Staff told us they identified and quickly acted upon patients at risk of deterioration.

Staff were aware of the signs and symptoms of a deteriorating patient and had the training to recognise this. There had been no patients in the past year who had deteriorated rapidly while receiving treatment. Some patients were admitted to a ward at the host NHS trust, because of the specific treatment technique that was used. Those patients were cared for by the NHS trust and the ward staff were responsible for monitoring them while they were on the ward, this was set out in the service level agreement.

The service had a deteriorating patient policy but were not able to direct us to where sepsis was mentioned. There was also no mention of the sepsis six bundle throughout the department. Despite this, all staff were clear on the signs and symptoms of sepsis and how to safely care for patients whom they suspected had sepsis. We highlighted to managers that they needed to have clearer documentation to support staff to identify and care for patients with suspected sepsis.

Staff told us they were clear on how to care for patients who were deteriorating. The service had a nurse available at all times throughout a patient's treatment who would regularly carry out patient observations if the team were concerned. The service was also supported by consultant neurosurgeons and a clinical fellow. At all times a patient was on site the doctors were available and in the near vicinity. We were told if a patient were to deteriorate rapidly there was easy and quick access to senior medical staff.

Staff carried out preassessment checks of patients before they attended for treatment. The service did not use the World Health Organisation (WHO) safer surgery checklist as they were not carrying out surgery in the manner this was designed for. However, they used some of the principles outlined in the WHO checklist to form their preassessment checks. Staff initially identified patients and gave them an arm band, this was checked regularly throughout the day. Patients were also asked to confirm their diagnosis and the area they were expecting to have treated. Staff also checked their recent scans, to ensure they were still suitable for treatment, ensured they had recent blood tests that showed they were otherwise well and able to tolerate treatment and that they had recently had a COVID-19 test to know how to safely care for them during the COVID-19 pandemic.

Medical care (Including older people's care)

Prior to having the frame fitted all patients were risk assessed to be able to have an MRI, as there are some patient for whom MRIs are not safe. This was then reconfirmed by the diagnostic radiographers who were carrying out the scan. If a patient needed contrast for the MRI scan, there was another risk assessment carried out to ensure they were not allergic to the contrast agent. Contrast is sometimes injected before or during a scan, it makes some areas of the body look clearer on scans.

Staff shared key information to keep patients safe when handing over their care to others. We observed the treatment radiographers handing over the risk assessments to the diagnostic radiographers prior to scans being taken. We were also told there was good communication with staff on the ward patients were sometimes cared for on. Staff at the service had access to the electronic patient record at the host NHS trust. They could see all the notes ward staff made about patients. We were told staff also updated the electronic patient record with their observations, in addition to verbal handovers if patients were cared for on the ward.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave agency staff a full induction.

The service had enough staff to keep patients safe. Managers accurately calculated and reviewed the number of staff needed. Due to the specialist nature of the treatment delivered there was no national guidance for the number of clinical staff needed to run the service safely. The managers told us they monitored staff overtime to ensure they were not overworking their staff and as an indicator for when things were getting busier and they needed to invest in more staff.

The service had four radiographers who worked clinically, one of these was also a manager. The managers had identified a need to hire an additional radiographer. They were starting to treat more patients and they needed to maintain radiographer staffing flexibility to allow their staff to attend courses and training. The service also had one full time nurse to care for patients and to support with clinical needs outside the radiographers' scope of practice.

The service had low vacancy rates. The nurse had recently left and they were interviewing to fill the position. In the interim they had hired an agency nurse on a long-term contract to support the service. The managers had identified there was a need to hire an additional radiographer to their team, as described above, and this was due to be advertised soon after the inspection finished.

The service had low turnover rates. The service had no radiographers leave in the year prior to our inspection. The substantive nurse had left their role, we were told this was not due to concerns about the work or team.

The service had low agency usage rates and managers limited their use of bank and agency staff and requested staff familiar with the service. At the time of inspection the service had an agency nurse supporting them, due to their permanent member of staff leaving. This nurse was employed on a long-term agency contract and would stay with the service until a permanent replacement was hired.

Managers made sure all agency staff had a full induction and understood the service. We were told the agency nurse was given an induction checklist on their first day which included orientation to the area, where it was safe to go and not go and when and where all the equipment was kept, including resuscitation equipment. They were also taught how to put together and take apart the frames, as it was part of the nurse's role to support with this.

Medical care (Including older people's care)

The service did not ever use bank or agency radiographers if there was sickness or vacancies. We were told by managers, due to the specialist nature of the treatment delivered, it was not safe to book bank or agency radiographers who may be unfamiliar with the service to deliver treatment. Instead, they had a service level agreement with another gamma knife centre in England to share staff if numbers were low. The service told us they had never needed to use this agreement but had sent staff to their other centre to support them when their staffing levels fell below safe numbers.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment and meet the required base line for their contract with NHS England.

All medical staff at the service worked under practising privileges. Practising privileges means that staff are employed elsewhere but are allowed to work for another service in a limited, defined capacity. In this instance all medical staff were specialists with gamma knife experience. Most medical staff were consultants and were neurosurgeons by background or clinical oncologists. The service also employed a clinical fellow under practising privileges who worked with the radiologists to support their interpretation of the images.

The service had enough medical staff to keep patients safe and to meet the terms of their NHS England contract. Medical staff were always available and on site during every treatment, they were required to approve the plan and treatment area for every treatment. It was part of the contract with NHS England that this was maintained. The medical staff were also required to attend the multidisciplinary meetings to approve patients for treatment. This required both neurosurgical and clinical oncologist attendance.

Records

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

Staff always 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 all update.

Patient notes were comprehensive and all staff could access them easily. Patient records were kept both in an electronic system and also on paper, which were later scanned into the electronic patient record. The service used the host NHS trust's electronic patient record to keep a record of their referrals, multidisciplinary team meeting outcomes and treatments. However, on the day of treatment the service used a different system to plan, verify and record treatment. The gamma knife and planning software were not integrated into the main electronic patient record, this was due to the specialist nature of the software. After treatment staff ensured documents were scanned into the electronic system to maintain a contemporaneous record of treatment. All staff were able to navigate the electronic system with ease.

When patients transferred to a new team, there were no long delays in staff accessing their records. If patients were being cared for on an inpatient ward following treatment there was a slight delay before the treatment details could be uploaded to the main electronic patient record. However, staff would provide a full verbal handover of care.

Records were stored securely. All computers were logged off when not in use and any paper records were secured until they could be scanned into the electronic patient record.

Medical care (Including older people's care)

Following treatment patients were discharged back to the care of their referring clinician. A discharge summary was sent to the referring team to confirm that treatment had been completed and what dose and volumes were treated. Patients were then followed up locally.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. If patients needed medicines these were prescribed by the consultant in charge of their care, if they were not available the clinical fellow could also prescribe medicines.

Staff stored and managed medicines in line with the provider's policy. Medicines were prescribed electronically so there was no prescribing stationary to store safely. We observed that the medicine cabinet was always kept locked. The service's nurse was in charge of maintaining stock levels of medicines in the cabinet and ensuring stock was not due to go out of date.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. The service only routinely prescribed low level pain relief for patients to take home, if needed. They did not prescribe stronger pain killers as they were not needed following this treatment.

Some patients required a short course of steroids to reduce the side effects of treatment. The service prescribed the full course of steroids and made sure they explained to patients how to take the steroids and how to safely reduce their dose following treatment.

Incidents

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

Staff knew what incidents to report and how to report them. Staff were now able to describe how to report incidents and how incidents were followed up.

Staff raised concerns and reported incidents and near misses in line with provider policy. Staff were able to tell us what would be considered a serious incident, but the service had not had any incidents categorised as serious in the past year.

Staff understood the duty of candour. In the past year there were no incidents which required the duty of candour to be followed. However, staff knew they needed to be open and transparent, and gave patients and families a full explanation if things went wrong.

Managers investigated incidents thoroughly. Incidents and any actions arising from them were discussed at the weekly team meeting. This was then also recorded in the team meeting minutes for any staff who were not able to attend.

Medical care (Including older people's care)

There was evidence that changes had been made as a result of feedback. The service recorded all incidents on their incident register. The incident register logged actions arising from incidents and progress to achieving them and was also used to look for any themes. If the incident was indicative of a theme then the concern was added to the risk register.

Staff were able to talk about recent incidents and what had been changed as a result of them. We saw the incidents and actions we were told about by staff members were reflected in the incident register.

All safety alerts went to the service manager. They then took the appropriate actions and informed staff, where necessary. They were able to give us a recent example of an alert they had received about a batch of face masks which was faulty. They explained they asked their nurse to check their stock of face masks against the faulty batch number. None of their stock was from this faulty batch so no further action was required.

The service had no (IR(ME)R) reportable incidents in the past year. There are certain incidents within IR(ME)R which need reporting externally, this service had not met these thresholds.

Are Medical care (Including older people's care) effective?

Good 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance, evidence-based practice and their contract with NHS England. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service contracted in medical physics support and part of the support was for the physicists to review any new policies and procedures or changes to policies and procedures. The physics support was specialised and focussed on gamma knife treatment.

As SRS is such a specialised field there are no NICE guidelines for the service to refer to, they instead refer to information published by the International Stereotactic Radiosurgery Society (ISRS) and the British Radiosurgery Society (BRS).

We reviewed a selection of the services' policies and procedures and found they contained clear, referenced up to date information. However, in their employer's procedures they referenced an old version of the IR(ME)R regulations. We found the content of the procedures reflected the most recent version of the regulations, and the document had been updated recently but, the previous version of IR(ME)R was referenced. The IR(ME)R team took action to ensure this was changed. Following the inspection, we received confirmation that this had been corrected.

The service audited its compliance with its policies and procedures. There were a number of audits carried out; one audit was completed by the lead clinician and the lead medical physics expert annually. They picked four random plans from every clinician and reviewed them against their policies and procedures to ensure the plan dosimetry was optimised and the prescription was correct and that clinically the appropriate areas had been treated. The audit had been completed in March 2021 and the results were going to be presented at the next clinical governance meeting. In addition to this audit all radiographers checked the plan complied with the published prescription before delivering treatment.

Medical care (Including older people's care)

The service spoke openly with another specialist gamma knife treatment centre to compare protocols and treatments. There was only one other service in England that was contracted to treat tier three and tier four patients with SRS. The two services spoke openly and shared protocols and policies to ensure treatment was comparable between the services and patients were receiving the same care.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. The service was an outpatient service but offered patients tea, coffee and water throughout their day. As patients could be there a number of hours the service also offered them food throughout the day. Patients told radiographers what they wanted and they went to get it from the canteen. If patients had dietary needs this was discussed before they attended for treatment.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain

Staff assessed patients' pain and gave pain relief in line with individual needs and best practice. Staff regularly asked patients how they were feeling and always enquired about their pain. We were told if there was a patient who had difficulty communicating the service could access pictures for patients to communicate pain needs. This could be used for patients with learning difficulties or for patients for whom English was not their first language or who used British sign language to communicate.

Patients received pain relief soon after requesting it. Staff gave patients pain relief almost immediately after they requested it. As the service always had consultants present there was no delay in prescribing pain relief when it was needed. The service kept a small supply of frequently used pain medicines in their medicine cabinet so there were no delays with having to go to pharmacy to get medicines dispensed.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes

Due to the nature of the treatments carried out, the outcomes for patients were very patient specific and benchmarking this data was difficult as there was no national database for easy comparison. The service did make efforts to audit their effectiveness. The service had access to a clinical fellow, whose specialism was gamma knife treatments. The clinical fellow was compiling data on the effectiveness of treatments in the long term and had been looking at years of data and reported side effects to analyse the effectiveness and efficacy of the treatment they were offering.

The clinical fellow used a number of methods to compile their data. They used reported side effects and follow up notes to understand the efficacy of treatments, and how patients felt after treatment. They also used follow-up MRI scans to overlay the plan to visualise how effective treatment had been. They explained to us that this needed to be done over a number of years as patients may appear to have an enlargement of their lesion before a decrease in size, but this could be

Medical care (Including older people's care)

due to swelling. Similarly, a patient could appear to initially have a good response but, later develop side effects and this needed to be accounted for in the study. The data that was collected by the clinical fellow was compared to international data, to give a bigger pool of patient data to compare against, this allowed the service to draw more valid conclusions from the information. Overall, the results of the study were positive, and they were planned for publication after more years of follow up.

Managers shared and made sure staff understood information from the audits. Information from all audits was shared at the quarterly clinical governance meetings and/or the weekly team meetings. These meetings had minutes taken, so any staff who could not attend were able to catch up and understand what had been presented.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Other aspects of the service were also audited by the radiographers. Regular health and safety, fire safety, infection prevention and control and hand hygiene audits were carried out, with good results. In addition to this the service carried out an annual audit of consultant plans to ensure they met the standards of their policies and procedures.

The service had ISO9001 accreditation. This meant their quality management system had been assessed as meeting certain standards by an external body.

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 to meet the needs of patients. All radiographers were qualified and registered with the Health Care Professions Council (HCPC).

Managers gave all new staff a full induction tailored to their role before they started work. Staff showed us their induction pack and clinical competencies. These were broken down into sections to ensure staff were confident with each part of a treatment procedure. Staff told us they did not feel this had been a tick box exercise but that they had a conversation about each treatment technique before signing it off to ensure they really understood what they were doing.

Consultants who were new to the service were also expected to complete competencies with a consultant with gamma knife planning experience until they demonstrated they were approving high quality plans and in a timely manner. They were then signed off and allowed to work without the supervision of another consultant. This was because the service had identified that gamma knife treatments were not standard in the training to become a neurosurgeon and therefore even an experienced neurosurgeon might not fully understand the principles underpinning the treatment. The service therefore trained the neurosurgeons they worked with before allowing them to sign off on their own treatments.

Staff roles under IR(ME)R were clearly recorded in the employer's procedures. This was then further clarified with a summary signature sheet, that was kept near the treatment console. The signature sheet had all staff member names, their role under IR(ME)R and a copy of their signature. This meant clinical staff could make sure the right people were signing for the right things and that their signature was valid.

Managers supported staff to develop through yearly, constructive appraisals of their work. 100% of staff had an appraisal in the past year. Staff told us they found their appraisals useful and they had identified learning and development opportunities at them. Following appraisals, managers told us that staff had identified masters courses to attend and that one member of staff was given time to attend their course and another was due to start later in the year.

Medical care (Including older people's care)

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Weekly team meetings were scheduled for a Thursday, this was because the service did not often treat patients on a Thursday, due to MRI availability. This meant clinical members of the team were all able to attend the meeting. For those who were on annual leave meeting notes were taken each week and these were made available for staff. We saw examples of the meeting notes and found they were clear and informative.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff were given dedicated time to undertake training and continuous professional development (CPD). We were told staff were allowed to use work time to attend courses or undertake work towards their further education.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Radiographers told us they were happy to bring up training needs with their managers and found these were often supported. Members of the team were on various courses to extend their scope of practice and were scoping out the potential to push this further with prescribing courses in the future.

Multidisciplinary working

Doctors, radiographers and other healthcare professionals worked closely together as a team to benefit patients and create a smooth pathway. They supported each other to provide good care.

Staff held regular multidisciplinary meetings to discuss patients. All patients who were referred into the service were discussed at a specific multidisciplinary team meeting where the sole purpose was to consider the referrals and make decisions about whether gamma knife treatment was a viable option. These multidisciplinary meetings were attended by wide range of professionals to support the decision-making process and happened weekly, so there was no backlog. The NHS England contract specified certain staff who must attend each meeting, we found that these obligations were now met.

The service had set up a new multidisciplinary meeting, specifically to discuss patients with arteriovenous malformations (AVM) with their referring clinicians. An AVM is when blood vessels get tangled and form abnormal connections between themselves. The service had identified this was a pathway that was not always smooth for patients and they often had long email correspondence with referring clinicians before they had all the information they needed to discuss the case at their internal multidisciplinary meeting. To reduce this, the service had set up an external multidisciplinary meeting, which happened monthly. This allowed them to discuss referrals with the referring clinicians and fully explain the requirements to be discussed at the local multidisciplinary meeting. Within three months of this starting the meeting had grown from being a local discussion with NHS trusts in London to the whole of the South of England. This process was speeding up the referral process for patients and allowing quicker access to care and treatment.

We observed close multidisciplinary working between doctors, medical physicists, radiographers and the nurse. All staff spoke openly and respectfully with each other and this enabled efficient patient care, for example when patients needed pain relief this was available almost immediately.

Seven-day services

The service was open Monday to Friday for outpatients. There were plans to possibly open into the weekends, as patient referrals increased, but at the time of inspection this was not required and all patients could be accommodated in the week. If patients needed support outside of their opening hours they were advised to contact their referring hospital or clinical nurse specialist from the NHS trust that referred them, as they had oversight of the full patient pathway.

Medical care (Including older people's care)

Health promotion

Staff gave patients practical advice.

The service had relevant information available for patients about driving following treatment. Due to the potential side effects following treatment the DVLA had rules about driving following some treatments. The service made sure all patients were aware of the rules and potential restrictions before and after their treatments.

If patients had wider questions about leading healthier lives they were able to ask the team, the team knew to refer them back to the clinicians or their clinical nurse specialists (CNS) who had wider oversight of their treatment pathways.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff gained consent from patients for their care and treatment in line with legislation and guidance and clearly recorded consent in the patients' records. This process was audited regularly to ensure consent was being gained at the correct point in time and that it was being correctly recorded. The most recent audit found that 100% of patients had the correct consent forms completed and signed. However, due to the pandemic, most patients were signing their consent forms on the day of treatment. This was not in line with best practice, which was to gain informed consent before the day of treatment and to then confirm consent on the day of treatment. Staff explained it was currently done on the day of treatment to reduce the number of times a patient needed to attend hospital during the pandemic. The service had recently set up a system and trained staff to hold the consent conversations over the telephone and then to confirm this on the day of treatment. This was being rolled out at the time of inspection.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were clear about what could affect a patient's ability to consent to their treatment and when they would request for a patient's capacity to be assessed, if they had concerns. Radiographers told us, because they worked so closely with the doctors on the day of treatment, they would always be able to ask for a medical opinion on capacity if they were concerned.

Staff made sure patients consented to treatment based on all the information available.

The service treated some children and young adults. They were managed by a local paediatric specialist NHS trust. The NHS trust was responsible for these patients and carried out all consent procedures.

Are Medical care (Including older people's care) caring?

Our rating of caring stayed the same. We rated it as good because:

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs

Medical care (Including older people's care)

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients in a respectful and considerate way. Patients could be in the department for extended periods of time, due to the time taken to plan treatments and to sign off the plan safely. We observed radiographers, the nurse and the clinicians being attentive to each patient's needs and checking in with them to see if they could support any further.

Staff regularly updated patients with what was happening with their treatment, and how long it was expected to be and explained what was happening.

We were told if treatments were expected to take a few hours staff offered patients breaks throughout the treatment. They explained to patients that they would do this and they would ensure these breaks were at points in treatment which were safe.

Due to the radiation being used staff could not safely be in the treatment room with patients while treatments were happening. However, we observed staff speaking over an intercom to patients throughout their treatment and keeping them updated with how long the treatment would take.

Patients said staff treated them well and with kindness. One patient told us they were initially worried about the treatment, as it was not like anything they had ever experienced, but that the staff had been really nice and they were very pleased with their experience. Another patient told us they had previously struggled to be listened to by other departments but, they felt the service was really good and the staff had treated them kindly and like a person and not a patient.

Staff followed policy to keep patient care and treatment confidential. Patients had their own individual waiting rooms. These rooms had doors that could be shut, if patients requested privacy, although we observed patients preferred to leave them open. During the frame fitting patients were taken into a separate room, the door closed and the procedure was carried out, maintaining privacy.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. The service offered access to a counsellor free of charge to support patients who were nervous about the treatment. We were told a number of patients were very worried about having the frame fitted and the counsellor could offer support to alleviate that worry and to teach patients techniques to calm themselves down. Similarly, some patients may suffer anxiety following treatment and the counsellor supported with that also.

Due to the COVID-19 pandemic the radiographers did not give patients a tour of the service to explain everything before their appointment as they worked to minimise the number of times patients attended the hospital. They instead spent time speaking with patients on the phone to explain as much as possible to them before they attended the hospital, this was also backed up with leaflets that were posted to patients.

On the day of treatment the radiographers worked with one patient, this meant the patient had a familiar face all day if they had any questions they wanted to ask. We were told patients often commented it was nice to put a face to the name that had been calling them in the run up to their treatment, and that they appreciated seeing the same person all day.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Medical care (Including older people's care)

The service funded access to a wellbeing smartphone application to support patients after their treatment. The application was designed with people who had experienced cancer and offered a holistic approach to wellbeing including yoga classes, meditation, music or conversations with people experiencing the same thing. All patients could access the application for free for a year following their treatment.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Before a patient arrived for treatment they had multiple discussions with the radiographers about what to expect on the day. The service sent out letters and leaflets to back up what had been discussed on the calls. These included photographs of the environment and frame so patients were clear about what to expect. Throughout the day we observed all staff explaining what was happening and giving patients opportunities to ask questions about what they had just been told.

Due to the COVID-19 pandemic, at the time of inspection patients could not routinely bring a loved one to support them. We observed staff offering to call patient's loved ones to keep them up to date with what was happening and how long they would be. We were also told if patients needed to bring carers with them this was permitted, and the carer was asked to isolate and carry out COVID-19 tests to keep the patient safe also.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. All patients were asked to fill out a feedback questionnaire following their treatment. We observed the radiographers encouraging patients to do this, explaining their feedback was needed to make changes to the service to benefit future patients.

Patients gave positive feedback about the service. We saw the feedback from the patient satisfaction survey for the three months before the inspection. Of the patients who responded 100% said they found the consultant helpful, were very satisfied with the service delivery, helpfulness of staff and their overall experience. Of the patients who responded 100% would recommend the service. The service also asked for any additional comments following the survey and took some learning from this about the availability of music and how to help patients manage with the frame. We saw this was reflected in the learning points in the survey results.

Staff could give examples of how they used patient feedback to improve daily practice. This reflected the comments that we saw in the patient satisfaction survey.

We were told that for patients who independently funded their treatments the costs were made clear before starting the treatment.

Are Medical care (Including older people's care) responsive?

Our rating of responsive stayed the same. We rated it as good because:

Medical care (Including older people's care)

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The service was contracted by NHS England to be one of two specialist centres in England to provide specialist stereotactic radiosurgery to all categories of patients. This meant for tier three and four patients they cared for patients across the whole of the South of England. Tier three and four patients were classified by NHS England and had more rare conditions, they were limited to attend the two specialist centres to ensure the expertise was concentrated to treat the rare conditions safely.

Managers planned and organised services, so they met the changing needs of the local and wider population. During the COVID-19 pandemic the managers had arranged with the host NHS trust that their patients could be scanned first on the MRI lists. This was because their patients had been required to isolate at home and by scanning them first they minimised the risk of cross contamination with other patients, such as emergency admissions, who had not been able to isolate.

The service also arranged taxis to bring all their patients to and from the hospital during the COVID-19 pandemic. Managers explained this was to prevent patients feeling they had to get on public transport and to help keep them safe. If patients were travelling long distances the service arranged hotel stays for them the night before treatment, if they did not need to be admitted to the ward.

Facilities and premises were appropriate for the services being delivered. The service did not have a toilet in their facility. However, just down the corridor they had access to a disabled toilet for patients to use. Patients were taken there in wheelchairs, once they had their frames fitted.

The individual patient waiting rooms meant patients, who sometimes had long waits while treatment plans were being finalised, were given privacy and somewhere they could feel comfortable. The rooms were big enough for wheelchairs to fit in and had additional seating for patients to bring loved ones, once this was allowed again after the COVID-19 pandemic. We were told the rooms were not big enough to fit a trolley in, however, if a patient needed to be cared for on a trolley the service would know this ahead of time and would only book one patient that day, to maintain their privacy.

Managers monitored and took action to minimise missed appointments. Managers told us patients did not miss appointments, they occasionally had patients cancel at short notice, but they did not have patients not turn up on the day.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service had access to flash cards to communicate with patients with a disability or sensory loss. Patients with additional needs were also allowed to bring carers, even throughout the COVID-19 pandemic, to ensure the service was meeting their needs. If a patient had hearing loss the service used the hearing loop facilities in the MRI department to support their care.

Clinical areas met the needs of patients living with dementia. The department was small, secure and quiet. All patients were given their own waiting room to sit in and were cared for primarily by one radiographer throughout the day.

Medical care (Including older people's care)

The service did not have information leaflets available in languages spoken by the patients and local community. Managers told us if a patient needed a leaflet in a different language they would get this translated on a case by case basis.

Managers made sure staff, patients, loved ones and carers could get help from interpreters when needed. Staff told us they used a telephone translation service for patients who did not speak English as a first language. They told us they only needed to use this occasionally but found that it worked well, even for consultations held over the telephone.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff spoke with patients before they attended for their treatment over the phone. They would speak to patients about their dietary needs. Patients were welcome to bring their own food and snacks, if they wanted. We observed patients being offered pastries and snacks throughout their time in the department. One patient did not want a pastry but wanted a cooked breakfast instead, the radiographer went to the hospital canteen to purchase the cooked breakfast the patient had requested.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment were in line with national standards.

In the year before the inspection the service had cared for 334 patients. The service had continued to operate and care for patients whose treatments were time critical throughout the COVID-19 pandemic. With the support of their clinical lead they had devised criteria for patients who would and would not be accepted in the peaks of the pandemic, this was based on risk to patients of having their treatments delayed. At the time of inspection the service was treating all patients again.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service treated some patients for whom there were national waiting time standards, such as patients with brain metastases. These patients needed to be treated within two weeks of referral. In the year before the inspection the service had met this target. They had designed their service to allow for this target to be met, with their meetings scheduled to compliment other meetings to improve the speed of access into the treatment.

For other patients, who were not part of the national waiting time standards the service was careful to monitor their waiting times. They used a computer programme to monitor all referrals the service had, how long people had been waiting for care and the reasons for this. The information was anonymised to share at multidisciplinary team meetings for further discussion. We were told there were quite a few patients on their referral list, but these were patients who were choosing to wait for their treatment and were being monitored by their referring centres. If a patient wanted to have their treatment as soon as possible and the service had all the correct information from the referring centre, they were averaging a three week wait before treatment was delivered. We heard one patient being discussed whose treatment was not time critical and had chosen to wait one year for their treatment.

Managers and staff worked to make sure patients did not stay any longer than they needed to. The day in the department could be long, as the treatment was complex and there were a number of steps required before it could be delivered. We observed staff working hard to make the day as efficient as possible. All required staff were present, the neurosurgeons had dedicated time to spend in the department to plan and approve the treatment, so there were no delays in finding them or requesting their sign off. We were told treatments could sometimes take a number of hours to deliver, the clinical staff regularly gave patients updates about how long they would need to be in the department.

Medical care (Including older people's care)

Managers worked to keep the number of cancelled treatments to a minimum. We were told patients did sometimes cancel their treatments, however this was infrequent as the service had lots of contact with them in the lead up to their treatment to thoroughly explain the procedure to them to reduce any anxiety about this. In the past year the most common reason for cancelled appointments was because a patient had tested positive for COVID-19 and if their treatment was not time critical they had been delayed.

When patients had their treatments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national waiting time standards and guidance. The service worked with another local gamma knife service to continue care for patients if there was a cancellation because of machine breakdown at the centre.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

Patients, relatives and carers knew how to complain or raise concerns. Patients were openly asked for their feedback on the service.

The service had never had a formal complaint made about them. However, there was a complaints policy and staff understood the policy knew how to handle complaints if one were to be made. The policy allowed for escalation of a complaint should a patient not be happy with the response they received. The service was subscribed to an independent adjudication service, to ensure there was external oversight of their procedures, should this ever be needed.

Staff knew how to acknowledge complaints, if a patient made a negative comment during their treatment we were told staff would try and address it immediately.

Due to the lack of complaints the service used the comments in the patient survey to identify areas for improvement.

Are Medical care (Including older people's care) well-led?

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

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.

The service was led locally by the service manager who was supported by the clinical lead and the supervisor of clinical operations. The service manager and the supervisor of clinical operations were both registered managers and had worked in the service for a number of years. The service managers reported to the corporate managers regularly but had oversight and responsibility for the daily workings of the service. They told us they felt supported by the corporate leadership team, who helped with the business development while the registered managers were able to focus on the clinical development.

Medical care (Including older people's care)

All staff we spoke with spoke highly of their managers, they told us they were approachable, supportive and knowledgeable. They were able to highlight any concerns they had to them. We were told by radiographers they were supported to take on additional learning to develop their roles, they were being supported to study for masters degrees and other additional learning such as cannulation training and prescribing training, all of which allow radiographers to extend their roles.

The service was in the process of putting an advert out for an additional, junior radiographer. We were told this was to allow staff to focus on their studies and to have a member of the team with more scope for progression.

The managers told us they were proud of their team and the service they offered to patients. They felt they really cared for their patients and were experts in their area. They were also pleased to be allowed to focus on the clinical development of the service and were working with partner NHS trusts to streamline care for patients.

Vision and Strategy

The service had a vision for what it wanted to achieve and a plan 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.

We saw the service had its vision displayed in their corridor it read “To provide a service which puts the patient first, providing exceptional patient care and experience, working to make SRS accessible to all that can benefit”. Staff were all aware of this vision.

There was a business plan to put the service’s vision in to practice. The plan was developed with the provider company and focussed on expanding the service in a safe and sustainable manner, to benefit the patients who would benefit from treatment.

The plan laid out how the service was planning to double their patient appointments in a safe way, utilising technology to facilitate this. It was thorough and looked at all parts of the pathway, and considered the extra time required by clinicians and other health care professionals. The service had invested in more software to allow plans to be created and approved faster, this would not only reduce the time patients needed to be in the department for but, the software maximised the efficiency of the treatment, meaning the patient treatment time was generally able to be reduced.

In anticipation for the increase in patient referrals the service had employed a new multidisciplinary team meeting manager. This manager had oversight of the service’s multidisciplinary team meetings, their referrals and any waitlists.

The plan was not only focussed on increasing the number of patients treated at the service but also improving their experience of care and their general wellbeing. The service had funded access for patients to a counselling service to support patients with their concerns either before or after treatment. They had also funded access to a wellbeing application on smartphones to care for patients holistically.

Culture

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

Medical care (Including older people's care)

All staff we spoke with told us they were happy to work at the service and felt they played an active part in the development of the service. Radiographers told us they were able to question decisions by clinicians if they disagreed with them. We were told there were open conversations about how to best care for patients and everybody's opinions were respected.

We observed patients were cared for in a professional manner by all members of staff and were encouraged to share their views on the service.

We were told by staff that this was a nice place to work, that they felt able to focus on caring for patients and that everything was well organised, which enabled them to give as much time as possible to their patients.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. 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.

The service had a complex, well defined, integrated relationship with the host NHS trust. The relationship was now well managed, there were regular meetings the two organisations attended to discuss the needs of the service and how these could be balanced with the needs of the host NHS trust. The service had a robust service level agreement securing them access to a broad range of services provided by the host NHS trust, these have been discussed throughout the report. To ensure communication was clear between the host NHS trust and the service there was a named point of contact that the service could contact to raise or escalate issues or concerns to the host NHS trust senior management team.

The service manager told us they felt supported by the host NHS trust and that they were able to speak openly with them, and able to access the additional care their patients needed.

The role of the service manager was well defined now, they had responsibility for the day to day running of the service and overseeing any improvements and projects to improve services for patients. They managed the relationship with their parent company and with the host NHS trust.

There were now regular quarterly governance meetings. We saw the agenda for these meetings was consistent and always covered in the notes. The governance meetings had representation from The Gamma Knife Centre at the National Hospital for Neurology and Neurosurgery, the clinicians involved in patient's treatment, the host NHS trust and the parent company of the service. This allowed all parties to have open and clear discussions about the current service provision and aspirations for the future. The clinical governance minutes we saw were clear and had actions which were assigned to specific people. Standard agenda items included things such as reviewing all DBS checks were in date for clinicians, risks, incidents and operational data.

The service no longer held specific medical advisory committee meetings. Due to the size of the service this meeting was merged with the clinical governance meeting. We saw evidence in the minutes of discussions about clinician's rights to practice at the service and chasing disclosure and barring service (DBS) updates for current clinicians and indemnity letters from others. There was now a clear audit trail of what had been requested from clinicians who were able to practice at the service and that recruitment checks had been completed fully.

Medical care (Including older people's care)

The service now had clear records of all clinicians recent DBS checks, proof of indemnity insurance and a valid scope of practice. They also had the dates of the clinicians most recent appraisals at their home NHS trusts. To make this available to staff in a format that was useful this information was added to the service's entitlement matrix. The entitlement matrix clearly laid out the clinician's areas of practice and what they were able to treat and what they couldn't.

More locally the service ran weekly team meetings, these were scheduled for a day when staff did not often treat patients, due to MRI availability, and therefore they were able to take time from their day to attend the meeting. This was to encourage good attendance. We saw, from minutes, these meetings were well attended and had careful minutes taken, for anybody who could not attend. The minutes showed they regularly discussed what had happened in the past week and whether there was any learning that needed to be shared. Staff told us they found these meetings useful to understand the changes in the business and that they were able to bring forwards any ideas for improvements to these meetings.

We found the service was now meeting the required standards of their contract with NHS England. There was clear evidence and audit trails of clinical oncologists attending multidisciplinary meetings to support with decision making. These oncologists also had backgrounds which meant they had knowledge of and experience in planning gamma knife treatments. The service now worked closely with three clinical oncologists, this meant if one was away or unable to support the service there were two others who could be contacted for support.

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.

The service had a risk register that was formally updated every three months and was shared and discussed at the clinical governance meeting. We saw the current risk register and noted the risks were clearly documented and there were mitigations and evidence of them being regularly reviewed. In between the quarterly updates the service maintained an incident register. The incident register was a live document that tracked any incidents that had been reported in the incident reporting system or concerns that were raised at the weekly team meetings.

The incident register clearly logged every incident that had been reported on the incident reporting system and tracked any changes made. We saw there was evidence of this document being updated on a regular basis, and that actions identified were reflected in the practice we saw. Radiographers told us they were aware of the incident register, that they discussed it at every team meeting and were able to tell us changes that had been made as a result of recent incidents.

The service had a plan in place to manage any unexpected events. They were in the process of redefining a service level agreement with another local gamma knife centre to allow them access, should there be an unexpected event that meant they could not treat patients at their own centre. We were told the parameters of the agreement and that there were mitigations in place to reduce any risk to patients being treated elsewhere.

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.

As previously described the service carried out several audits to ensure treatments were effective and were not causing unnecessary side effects. All staff we spoke with were aware of these pieces of work and there were plans to publish the data in the future, when long enough follow ups had been carried out with enough patients.

Medical care (Including older people's care)

There was a new system in place to track referrals and how long patients had been waiting for, and the reasons for this. Staff were all aware of this system and were able to use it to monitor patient wait times.

The service was aware of the notifications that needed to be submitted to CQC but had not needed to submit any. Managers told us they submitted notifications to other agencies as required and gave us an example of confirming with the Environment Agency that their old radioactive sources had been disposed of correctly.

Engagement

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

Staff were observed to ask patients for their opinions on the service to ensure changes and improvements were made that would benefit them.

Managers confirmed they did not carry out a staff survey, however there were weekly meetings with staff where they could bring up any concerns or ideas for improvements. Clinical staff confirmed they felt able to bring up ideas for improvements at these meetings and could speak openly with managers and clinicians.

There was regular engagement and discussions with the host NHS trust to ensure patients had a smooth journey. This was both locally, between clinical teams, and more strategically, between service managers.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research

The service was working to improve education to external clinicians about the benefits and uses of stereotactic radiosurgery. They had developed a series of webinars to raise awareness of the service, these webinars were continuous professional development (CPD) accredited, the first webinar was held in October 2020, with another in February 2021.

The service had several proposed research studies looking to improve services for patients in the long run. These research studies were wide reaching in their scope and were focused on both improving outcomes for patients and reducing side effects. The studies had funding approved and were pending ethics approval. Some research studies were planned to be managed locally and some were planned to run with other hospitals to reach a wider patient group. Staff spoke excitedly about the proposed research and its potential impact for patients. All staff were included in the plans, including both administrative staff and clinical staff.

The service had invested in new equipment and treatment planning software to improve the service they were able to offer patients. It enabled more efficient treatment pathways and therefore reduced time in the hospital for patients.