

Festival Medical Services

Festival Medical Services

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?

Inspected but not rated



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Requires Improvement



Summary of findings

Overall summary

This service had not been previously inspected. We rated it as good because:


- The service had enough staff to care for patients and keep them safe. Staff completed mandatory training in core subjects and knew how to keep people safe and protected from abuse. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. Staff knew how to report patient safety incidents.
- Staff provided good care and treatment and managers monitored the effectiveness of the service. Staff worked well together for the benefit of patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions.
- The service planned care to meet the needs of the people who attended the events, 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 for treatment. Staff went above and beyond to make adjustments to help meet the needs of individual patients.
- Leaders had the skills and abilities to run the service and were visible and approachable. The service had a vision for what it wanted to achieve. Staff at all levels were clear about their roles and accountabilities. Risks were recorded effectively.

However:

- The service did not always make patients aware they could request a chaperone.
- Checks of radiographer compliance against identify confirmation needed to improve. Staff meetings did not follow a standard agenda to ensure consistency.
- Not all policies had effective from dates and many had not been signed to confirm they had been authorised. Paper copies of x-ray requests and reports were not scanned and stored electronically off site. Governance systems were not yet tested or embedded and not all available information was routinely being reviewed.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	This service has not been previously inspected. We rated it as good. See the summary above for details.

Summary of findings

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Summary of this inspection

Background to Festival Medical Services

Festival Medical Services is a not-for-profit registered charity that provides doctors, nurses, paramedics, first responders and allied healthcare professionals (including radiographers) to music festivals and outdoor events throughout the UK. The service also offers offsite transfers for the events it covers on a contract by contract basis.

The service is registered for the regulated activities of:

- Diagnostic and screening procedures
- Transport services, triage and medical advice provided remotely

Under the Health and Social Care Act 2014, transport services, triage and medical advice provided remotely (referred to throughout the report as 'patient transport') includes transport services provided by means of a vehicle which is designed for the primary purpose of carrying a person who requires treatment. However, it includes the following exemptions:

- Transport services which are provided within the confines of the site or venue being used for an activity or event mentioned. This means, that as soon as the vehicle transporting the patient leaves the boundary of the event, we can inspect this regulated activity.

The service was contracted to provide offsite patient transfers for one event in 2022 but did not perform any offsite transfers, so the regulated activity of transport services, triage and medical advice provided remotely was not inspected as part of this inspection.

For diagnostic imaging the service operates on a contract by contract basis and provides imaging services for two major festival events a year in South West England (Glastonbury and Reading)

The service also provides onsite medical cover for around 24 other events. However, this does not fall into the scope of registration, this means we cannot inspect this aspect of the service.

All diagnostic imaging equipment (including maintenance) is supplied and provided by a third-party provider.

Diagnostic imaging is provided 24 hours a day for the duration of each festival and manned by volunteer staff who are qualified Health and Care Professions Council (HCPC) registered radiographers. The service has 14 radiographers and five radiologists, all of whom are volunteers, including the service lead.

For the events season 2022 which ran between January 2022 and August 2022, the service undertook 302 x-rays and 5 ultrasound scans across the two events it provided diagnostic imaging services for.

This service was registered in December 2012 and has not yet been inspected under our new methodology.

We inspected the service in July 2013 under our previous methodology and all standards were met.

The service has had a registered manager in post since 28 December 2012.

Summary of this inspection

How we carried out this inspection

The team that inspected this location comprised of two CQC inspectors, one with expertise in diagnostic imaging. We spoke with seven members of staff including the registered manager, four patients and observed interactions with patients throughout the day. We reviewed documents and records kept by the provider and inspected the mobile x-ray room. We conducted two site visits, one at Reading festival to observe care and treatment and a follow up visit at the service headquarters to review governance processes.

There were no special reviews or investigations of the location ongoing by the CQC at any time during the 12 months before this inspection.

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>.

Outstanding practice

We found the following outstanding practice:

- The service ensured that where safe to do so, fractures were imaged and treated so patients did not have to attend the local NHS trust and increase pressure on the local system.
- Patients could access a multilingual feedback form by scanning a QR code.

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. 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 **MUST** take to improve:

The service **MUST** ensure all governance processes are fully developed and embedded and review and encompass all available information, including risk and incident data for the service. **(Regulation 17 (2) (a))**

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

The service **SHOULD** ensure all policies are authorised and have start and review dates.

The service **SHOULD** consider using standard agendas for staff meetings

The service **SHOULD** take steps to improve identify check compliance.

The service **SHOULD** consider displaying chaperone posters for patient awareness.

The service **SHOULD** explore scanning paper copies of x-ray reports and securely store them electronically.

Summary of this inspection

The service SHOULD make sure all staff have completed basic or immediate life support training updates.






Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Inspected but not rated	Good	Good	Requires Improvement	Good
Overall	Good	Inspected but not rated	Good	Good	Requires Improvement	Good

Diagnostic imaging

Safe	Good 
Effective	Inspected but not rated 
Caring	Good 
Responsive	Good 
Well-led	Requires Improvement 

Are Diagnostic imaging safe?

Good 

We have not rated safe before. We rated it as good.

Mandatory training

The service monitored staff compliance with mandatory training. However, not all staff had completed it.

Staff kept up to date with their mandatory training. Staff regularly undertook mandatory training with their main employers and submitted evidence of compliance at the beginning of each festival season.

The mandatory training was comprehensive and met the needs of patients and staff. The service had a training matrix which showed six mandatory training subjects for all staff and had evidence to show most staff had completed it.

There was evidence all staff working with radiation had appropriate training in the regulations, radiation risks, and the use of radiation. We saw from training records; staff had received training in the Radiation (Medical Exposures) Regulations (IR(ME)R) 2017 which was included as part of the local induction. All staff had undertaken this training at the time of our inspection.

Training compliance was monitored centrally by Festival Medical Services. Managers monitored mandatory training and alerted staff before the beginning of the festival season if their training was due to expire.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia although these were not core mandatory training subjects required by Festival Medical Services.

As part of event contracts, staff were required to complete event specific training such as counter terrorism. Festival Medical Services checked all staff had completed this before they could work at the event. 100% of staff had undertaken this site-specific training before working at both festivals.

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.

Diagnostic imaging

Staff received training specific for their role on how to recognise and report abuse. Staff maintained up-to-date mandatory electronic learning, which included Safeguarding Vulnerable Adults, Safeguarding Adults at Risk and Safeguarding Children modules. Training compliance was 100% for all staff, and staff received level two safeguarding training for both adults and children.

Staff had access to a member of staff who was trained in both adult and children safeguarding to level three. This member of staff provided leadership for safeguarding and worked with the multi-agency safeguarding hub for the safety and welfare of the patients. We saw during the morning operations meeting how all senior staff were updated with recent safeguarding concerns and actions taken to reduce any risk.

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff were aware of the service's Safeguarding Adults and Safeguarding Children Policies and referred to them if they had any safeguarding concerns. Safeguarding Leads' contacts for the local authority were displayed in the mobile imaging room.

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 also clean and well maintained.

Staff cleaned equipment after patient contact. We saw equipment cleaning was incorporated into daily cleaning checklists. In all clinical areas we saw specialist cleaning wipes and saw staff using them to clean equipment between each patient.

Staff followed infection prevention and control principles, including the use of personal protective equipment (PPE). The service had a comprehensive infection, prevention and control policy. The provider had a central stock of PPE at head office and a system for reporting and ordering system to provide an effective and efficient stock of PPE and cleaning materials.

Precautions were taken when seeing people with suspected communicable diseases or blood borne diseases such as influenza or monkey pox. Where a patient was known or suspected as having a communicable disease, they were imaged when no other patients were waiting, and the room was deep cleaned after the x-ray was performed.

The service used infection control measures when carrying out a consultation or performing a scan which included the use of face masks, aprons and gloves.

The service carried out daily and weekly infection prevention and control audits and the latest weekly and daily audits (conducted by onsite infection control staff during the festival) showed 100% compliance.

Diagnostic imaging

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Environment and equipment

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

The design of the environment followed national guidance. The design of the mobile x-ray room complied with IR(ME)R 2017 requirements and ensured staff and patients were kept safe during radiation exposures.

In the event of equipment failure staff reported to directly to the third-party provider of the equipment, who remained responsible for the maintenance and provided 24-hour support. The service kept a log of faults and reported incidents.

Staff disposed of clinical waste safely. We saw lockable yellow clinical waste bins which were emptied after the festival by a third-party contractor.

Resuscitation equipment was readily available, the emergency grab bag was adequately stocked and there was evidence of regular reviews.

The imaging service had completed risk assessments for all new or modified uses of radiation, which were reviewed every two years or whenever a change occurred. This was last undertaken in June 2022 and signed off by the service lead in consultation with the Radiation Protection Advisor.

Risk assessments addressed occupational safety as well as considering risks to people who used services and the public. For example, doses of radiation to members of the public and to patient escorts, such as nursing staff. If a member of staff or carer needed to be present during an examination, the dose of radiation they received was recorded on a comforter and carers form and attached to the paper imaging request and stored in line with company policy.

The service ensured controlled areas (where ionising radiation was present) were restricted to authorised personnel only.

Ionising radiation was used to take x-rays and there was clear signage when ionising radiation exposure occurred to prevent accidental access.

The service ensured specialised personal protective equipment was available and used by staff and carers when needed. Staff showed us lead coats used by escorts and anyone who may be pregnant who required an x-ray.

The service had an equipment quality assurance programme for all scanning equipment and had input from a medical physics expert which was part of the contract with the provider of the diagnostic imaging equipment. Equipment was operated and maintained consistent with the manufacturers' recommendations.

There were service contracts for equipment and a clear process for maintenance of equipment and for reporting of any faults. As part of each service, handover documents were completed for the engineer prior to service and again from the engineer after service. Documents contained details of known issues and repairs plus a general report on the performance of the equipment.

The service managed aging equipment and equipment failures through the service level agreement with the imaging equipment provider. The service used the same model mobile room for all events requiring diagnostic imaging.

Diagnostic imaging

The service monitored staff for radiation exposure using dosimeters. Staff wore one on their torso or waist. Dose reports for staff from the previous year were requested prior to that start of the season so any abnormalities could be identified.

The service had enough suitable equipment to help them to safely care for patients.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised most risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff responded promptly to any sudden deterioration in a patient's health. There were clear pathways and processes for the management of people who were, or became, clinically unwell. In an emergency staff were able to summon help by using an emergency call bell. The call bell alerted the medical tent reception staff who communicated the emergency with medical and security staff. We saw the system was tested as part of each handover and worked well.

The service carried out scenario-based training, the most recent of which showed some issues accessing and transferring the patient out of the x-ray room in a resuscitation training scenario. An action plan had been written to address this with a target date of June 2023 in time for Glastonbury festival.

There were processes to ensure the right person got the right scan, at the right time. Staff reviewed all referrals in advance of imaging to ensure the request was justified and had come from an approved referrer. Radiographers conducted audits to check requests were justified and the latest data from June 2022 showed 100% compliance.

The service followed the Royal College of Radiologists' Standards for the communication of radiological reports and fail-safe alert notifications. There was a team of seven to eight consultant radiologists who each did three sessions on site, reporting on the images taken. There was 24 hour on call rota of consultant radiologists who remained onsite. The service did not have access to PACS (picture archiving and communication system). Images were reported on the mobile x-ray room vehicle and saved to disc. These discs were then stored securely at the headquarters.

Staff followed the Society of Radiographers "pause and check" guidance when checking patient identity before carrying out an x-ray. The service audited compliance with identity checks and the latest audit for June 2022 showed out of 14 patients, 2 did not have ID checked (85.7% compliance). The service lead explained feedback has been given to the relevant staff to improve compliance.

The imaging service ensured the radiation protection advisor and the medical physics expert were easily accessible for providing radiation advice. Medical physics and radiation protection assurance was provided by a local NHS Trust under a service level agreement.

As part of the handover of the unit, records of testing of the equipment were provided showing it was in good working order with no known faults.

The service appointed multiple radiation protection supervisors in departments which used ionising radiation. Staff told us they had attended specialist training to undertake the radiation protection supervisor role and we saw evidence to support this.

The service ensured the 'requesting' of an x-ray was only made by staff or persons in accordance with IR(ME)R. The service held a list of approved referrers and any requests received from persons not on the list were immediately escalated for clarification.

Diagnostic imaging

The service saw patient of all ages including children. On site medical staff had received adult and paediatric life support training in the event of a medical emergency. However, staff training compliance showed only 80% of staff had received basic or immediate life support training.

The service ensured staff were aware of people who were or may be pregnant before they were exposed to any radiation in accordance with IR(ME)R and for staff in accordance with Ionising Radiation Regulations (IRR) 2017. We saw posters displayed in patient areas telling them to speak to a member of staff before they were imaged. Pregnancy status was recorded and scanned into the electronic patient record system. Compliance with pregnancy checks formed part of an annual (IR(ME)R audit, specifically to comply with IR(ME)R Regulation 11(1)(f). The most recent audit from June 2022 showed 100% compliance.

The service was in the process of updating its pregnancy policy to include all patients up to the age of 56 to be asked what gender they were assigned at birth to ensure the safety of all patients of childbearing age, in line with Society of Radiographers guidance. This was planned to be completed by March 2023.

There were clear processes to escalate unexpected or significant findings both at the examination and upon reporting. Images and reports were turned around the same day. Staff reviewed paperwork at the end of each shift to ensure all images had been reported.

There was double reporting of all images by a senior radiologist after the event and patients were contacted by the medical team in the event of a missed fracture.

The service had a set of local rules and employer's procedures available to protect staff and patients from ionising radiation.

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 bank, agency and locum staff a full induction.

The service had 14 volunteer radiographers on record although at the time of our inspection six were fully signed off and had worked both the Glastonbury and Reading festivals.

The service had enough staff to keep patients safe. The service had six radiographers on site for the duration of the festival who worked a single handed on a rotational basis to provider 24-hour imaging.

Administrative support was provided by a part time administrative assistant.

The manager accurately calculated and reviewed the number of radiographers and support workers needed for each shift. The number of staff matched the planned numbers.

All staff who worked for the service received a comprehensive induction and the service recorded training details for the staff centrally which aligned with mandatory training required by the service.

All staff worked voluntarily and there was a waiting list for radiographers to join the service.

Diagnostic imaging

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.

Patient notes were comprehensive, and all staff could access them easily. There were no delays in staff accessing the records. Records were stored securely inside the mobile x-ray unit which was always staffed or locked.

The service ensured imaging requests were appropriate and included the relevant information to allow for requests to be justified in accordance with Ionising Radiation (Medical Exposures) Regulations (IR(ME)R). The practitioner/operator (radiographer) was responsible for vetting and approving requests from a pre-approved list of medical referrers. Any queries or issues were followed up by prior to the examination taking place.

All imaging request were brought to the x-ray room in person by the referrer for discussion prior to imaging. Images were viewed in the x-ray room where radiographers were involved in the interpretation and gave their immediate opinion to aid in diagnosis. This was further checked by the radiologists and followed up if there were any discrepancies when reporting the images.

We reviewed four patient request forms and saw all required information was present on all four forms, including protocols, medical history and clinical indication for the imaging.

As part of the justification process to carry out exposure to radiation imaging services usually attempted to make use of previous images of the same persons requiring the test. This was not possible due to the remote nature of the event.

Medicines

The service did not use or administer any medications.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored but were not always effective. When things went wrong, staff apologised and worked with organisation to give patients honest information and suitable support.

Staff knew what incidents to report and how to report them. All staff members had access to the incident reporting system. There was a clear policy and pathway to guide staff to identify and report incidents. The service had not recorded any never events. There had been no serious incidents reported in the past twelve months.

Staff could access the electronic reporting system by scanning a QR code with their mobile phones.

Managers shared learning with their staff about incidents. Staff we spoke to were aware of this and could give examples of shared learning. For example, staff told us about an incident during a previous festival in which a patient required emergency response in a hard-to-reach area of the medical services. As a result, a new emergency resuscitation grab bag had been initiated and shared as standard practise across the whole medical service.

Staff understood the duty of candour and could give examples of situations where it had been verbally applied. However, the service had not had any incidents requiring formal duty of candour.

Diagnostic imaging

Staff reported incidents clearly and in line with the service's policy and received feedback from investigations. Staff met to discuss the feedback and look at improvements. For example, staff we spoke with told us that during a previous event a patient trolley had malfunctioned which resulted in an injury of a staff member. We saw that this equipment had been repaired for use.

Managers investigated incidents thoroughly, and action taken as a result was effective. We reviewed incidents reported between February 2022 and August 2022 and saw the service recorded one incident relating to diagnostic imaging.

There had been no incidents reportable under Ionising Radiation (Medical Exposures) Regulations (IR(ME)R) in the 12 months prior to our inspection.

Are Diagnostic imaging effective?

Inspected but not rated 

We inspect but do not currently rate effective for diagnostic imaging.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. 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. Policies and procedures were made available to staff and were site-specific for the service.

Staff understood and followed best practice guidance including Ionising Radiation (Medical Exposure) regulations 2017 (IR(ME)R).

The service ensured radiation doses were kept as low as reasonably practicable.

The service had an image optimisation team who reviewed 10% of images taken. The latest audit showed that out of 40 images taken on 18 patients, 34 (85%) were fully compliant with all criteria checked. For the images which did not fully comply, three had mitigation recorded.

The service ensured it identified and implemented relevant best practice and guidance, such as National Institute for Health and Care Excellence (NICE) guidance. Staff signed to say they had read and understood the policies and procedures. When policies and procedures were updated, staff were advised by the organisation or registered manager of the change and updated policies were highlighted and discussed at team meetings.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Patients were provided with specific instructions relating to eating and drinking prior to their scan. This included drinking water for a period of time prior to an ultrasound scan.

Diagnostic imaging

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and to see if they were comfortable.

The x-ray and ultrasound procedures were painless, but staff monitored and checked with patients throughout the process to ensure they were comfortable. Staff assisted patients to move the parts of the body under examination into specific positions, which could sometimes be uncomfortable. Where necessary, doctors administered pain relief to help the radiographer obtain the images needed.

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.

Staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment, although due to the nature of the environment it was not possible to access electronic records. Paper records were instead kept up to date by all staff.

The service participated in relevant national clinical audits. The service regularly reviewed the effectiveness of care and treatment through local audit and national audit with a structured audit programme. These audits included a monthly hand hygiene, an annual image quality and an annual Ionising Radiation (Medical Exposures) Regulations (IR(ME)R) audit which had last been carried out in June 2022.

Radiographers carried out a set of audits which were themed, such as pregnancy checks and markers in field of exposure. In addition, onsite audits of image quality and accuracy were also carried out, the latest of which showed 85% compliance.

All reporters were included in programme report auditing. This was a randomised 10% surveillance audit undertaken by auditors independent to the reporting clinicians. This was a centrally coordinated audit process carried out by the organisation. The results were held centrally, with feedback provided throughout the year to reporters to allow for reflection and improvement of practice.

Competent staff

The service made sure staff were competent for their roles and provided support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. New staff were provided with induction training. Most of the radiographers worked for a large independent hospital and had a minimum of two years' experience in general x-ray. Once onsite, all radiographer's received full training on the equipment which was signed off by the service lead.

Staff had the opportunity to discuss training needs specific to the service with the service lead to develop their skills and knowledge. All staff working at the service over the past year had received an annual appraisal with their main employer and we saw evidence of this.

Managers made sure staff had received any specialist training for their role and requested evidence of training if there were any gap or expired training provided by the radiographers in their training evidence submission.

Diagnostic imaging

The service ensured relevant staff continued to maintain registration with relevant bodies. The service held records to show the professional registration for the clinicians was checked annually with the professional body. For example, radiographers were registered with the Health and Care Professions Council (HCPC) and radiologists with the General Medical Council (GMC).

Role specific continuous development and maintenance of existing skills and competencies was an ongoing process. The service lead completed an evidence, training and competency review before the start of each event season, and we saw all six radiographers and five radiologists had a signed scope of entitlement document which outlined what they could request and justify under IR(ME)R 2017.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked closely with referring consultants from the onsite accident and emergency and also with radiologists and other designated reporters. Liaison and communication took place face-to-face due to the nature of the environment.

Seven-day services

Key services were available to support timely patient care.

The service provided x-ray imaging 24 hours a day to cover the duration of the festival or event as defined in the contract between the service and the event organisers. Radiologists were on call 24 hours to assist with complex image interpretation and reporting.

Health promotion

There was limited evidence to inspect this within the diagnostic imaging service although the service provided extensive welfare support to festival goers.

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.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff understood how and when to assess whether a patient had the mental capacity to make decisions about their care. If staff felt a patient lacked the capacity to consent to the procedure, they would seek further advice. Patients were provided with mainly verbal information prior to their appointment to enable them to understand the planned diagnostic test.

Where children were x-rayed, staff understood the principles of Gillick competence and could explain when they would seek guidance if they had any concerns about children and young people under the age of 18.

Are Diagnostic imaging caring?

We have not rated caring before. We rated it as good.

Diagnostic imaging

Compassionate care

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

Staff were discreet and attentive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. We saw staff spoke to patients in a friendly and considerate manner and gave a high standard of care. Patients were offered a chaperone if requested but this was not displayed anywhere. All three patients we spoke with made positive comments about staff. One patient fed back through the service “They offer a lot of treatment that I wouldn’t expect at a festival e.g. X-rays but also smaller things like blister treatment. Thank you for your help”.

Staff followed policy and kept patient care and treatment confidential. Only one patient at a time was able to enter the imaging mobile so all conversations were totally private and away from any other patients.

Staff understood and respected the personal needs of patients and how they may relate to care needs. Staff gave patients more time for their imaging if needed. Staff made sure necessary equipment was available to help patients with mobility difficulties. Staff explained that because patients were spaced out, they never felt rushed to image and could take their time with each patient and support them on an individual basis.

Several members of staff told us they would want the same level of care for their children, some of whom had attended similar festivals.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients help, emotional support and advice when they needed it. All three patients we spoke to said that staff had been helpful and supportive. Staff supported anxious patients by allowing them to view the room and not rushing them.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff explained that patients could often be intoxicated and that they allowed companions to accompany patients to help them remain calm for their x-ray.

Staff understood the emotional and social impact a person’s care, treatment or condition had on their wellbeing and on those close to them. Patients told us staff understood that having an injury and possibly having to leave the event to seek treatment was disappointing. Patients also stated they were incredibly grateful that x-rays could be taken on site as it meant that for some, they did not have to attend a local NHS trust to find out if they had a fracture or not.

Understanding and involvement of patients and those close to them

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

Diagnostic imaging

Staff made sure patients understood their care and treatment. All three patients we spoke to said staff had explained care and treatment clearly. One patient said, “all staff were so kind and patient”. Another patient said, “Amazing service and so friendly”.

Due to the nature of the environment, written information was not available in all formats and languages specific to the imaging department, but patients could leave feedback for the service by scanning a QR code to access a multilingual app.

Patients and their families gave positive feedback on the service and their treatment and staff supported them to do this. Staff supported patients to make decisions about their care.

Staff talked with patients in a way they could understand, using communication aids where necessary. All three patients we spoke to said that staff had given them clear information.

Staff used translation services to aid communication where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We reviewed recent feedback from June 2022 which showed out of 81 responses, 62 (76.5%) definitely recommended the service and 14 (17.2%) probably would recommend the service.

Where patients had indicated they were unsatisfied or extremely unsatisfied, we saw actions recorded to address any specific issues.

A survey conducted by the service after Glastonbury showed two main areas of concern:

- Overall wait time, which was also highlighted in the Reading festival survey for 2021.
- Finding facilities, which was also highlighted in the 2021 Reading survey and focused on signs not being clear enough.

Actions suggested by the service included:

- Signposting – Conducting a walkthrough of the route people may take to find services which would help identify the need for better signage.
- Increasing numbers of radiographer staff to alleviate wait times.

Are Diagnostic imaging responsive?

Good 

We have not rated responsive before. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of people who attended the events and the communities served.

Managers planned and organised services, so they met the changing needs of the festival population. The service was purchased by the event organisers and took account of the needs of people attending the events.

Diagnostic imaging

The service provided diagnostic imaging (x-rays) 24 hours for the duration of the festivals. Ultrasound had been provided at Glastonbury, but the service had now been withdrawn due to limited use.

Facilities and premises were appropriate for the services being delivered. The facilities were appropriate given the nature of the environment they were provided. The waiting area for the x-ray facilities was in a small, quieter area of the medical tent with some seating for patients. A lift capable of accommodating wheelchairs and ambulance stretchers was attached to the x-ray lorry which enabled access directly into the x-ray room.

The service had systems to help care for patients in need of additional support. Patients who may be intoxicated were allowed to have someone accompany them, although if there were any concerns around the patient's ability to cooperate, a staff member from the medical centre also remained with the patient for the duration of the x-ray.

Managers monitored waiting times for x-rays but in most instances, imaging was immediately available when requested. A radiographer was always on duty in the mobile lorry.

The service did not need to monitor do not attend (DNA) rates as imaging was available, immediately, at the point of request.

All imaging referrals were hand delivered to the radiographer and once images were available, the referrer and radiographer reviewed the images together. There was section on the paper referral forms to record both the referrer's comments and the radiographer's opinion. Radiologists reviewed these comments and added their own report on the images in a dedicated section on the form.

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. They coordinated care with other services and providers.

Staff made sure patients living with mental health needs, learning disabilities or a diagnosis of a dementia, received the necessary care to meet their needs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. For patients who were visually impaired, staff ensured an appropriate person would be able to accompany the patient for their x-ray. This was also the same for patients who were intoxicated.

There was access to communication aids to help patients become partners in their care and treatment. The service had information leaflets available in other languages spoken in the local community or an 'easy read' format.

Translation and interpretation services were available on request through a telephone service line for patients whose first language was not English.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times for imaging were minimal.

Managers monitored waiting times and made sure patients could access services when needed and received the imaging they required.

Diagnostic imaging

Due to the nature of the service the monitoring of cancelled appointments was not necessary.

Imaging was immediately available once requested so the service did not need to monitor did not attend rates. However, the service did monitor instances where images were either sub optimal (due to injury or ability to cooperate) or examinations were abandoned. We saw from the latest image quality audit from June 2022, out of six images which did not meet all aspects of quality checking, three had clear reasons recorded for suboptimal images.

Managers and staff worked to make sure patients did not stay longer than they needed to. Once imaging had been performed, patients waited back outside the x-ray unit whilst clinical staff reviewed the images alongside the radiographers. Barriers preventing optimal imaging and clinical findings were discussed by the referrer and the radiographer who had performed the x-rays.

Patients were kept informed of any delays once they arrived in the department. Patients were usually asked to remain in the department as there was a risk if patients were allowed to go away and come back, intoxicated patients may not return.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

The service clearly displayed information about how to raise a concern in patient areas. Patients told us should they need to raise any concerns or a complaint they would start by speaking to the staff.

Staff understood the policy on complaints and knew how to handle them.

The service had an in-date complaints and concerns policy stating the roles, responsibilities and processes for managing complaints. The registered manager was responsible for dealing with all complaints. Complaints were initially responded to within 10 working days and investigated within 30 days. Complaint data was planned to be reviewed as part of the new governance structure and we saw some evidence this had begun in two sets of governance meeting minutes.

Managers investigated complaints and identified themes and where appropriate, shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice. Staff undertook a monthly analysis of feedback from patients. We saw in a post festival report from Glastonbury, several actions recorded including a signage review. Staff we spoke with were aware of these actions.

Are Diagnostic imaging well-led?

Requires Improvement 

We have not rated well-led before. We rated it as requires improvement.

Diagnostic imaging

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.

Leaders had the skills, knowledge, experience and integrity they needed both when they were appointed and on an ongoing basis.

The registered manager understood the needs of the service well, through attending regional and national meetings and liaising with other relevant stakeholders and event organisers.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The provider had a clear vision and a set of values, with quality and sustainability as the top priorities. The organisation had developed a vision, values and strategy which had been shared with the staff. Leaders understood the challenges to quality and sustainability, and they could identify the actions needed to address them.

Festival medical services was a not for profit company which, in addition to providing staff and facilities to large festivals, also awarded grants to charities. The service also provided significant amounts of medical supplies and equipment to the Ukraine to support people in the on-going war.

The service enabled medical staff to improve practices in less fortunate parts of the world through training and support.

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.

The staff we spoke with during inspection were open and friendly and spoke positively about working at the unit. They felt supported, respected, valued and proud to work for the organisation.

The service sought more information when patients' feedback showed dissatisfaction and took action to improve services.

The provider conducted a survey of staff following each event and collated feedback. Action was taken to address concerns including recruiting more radiographers to strengthen future onsite teams.

Staff were aware of the providers whistleblowing policy and the service had a freedom to speak up guardian.

Diagnostic imaging

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. However, 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.

Governance arrangements for reviewing incidents, complaints, risks and feedback were not yet fully embedded in the service. We saw a draft document which incorporated a pre event checks of key areas including event specific risk assessments, live action plan review, training overview and equipment quality assurance but this had not yet been introduced.

There were some structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. Staff at all levels were clear about their roles and understood what they were accountable for, and to whom. Policies and procedures were available to staff on the company website and were reviewed regularly and updated in line with national guidance and legislation although many were in draft format and did not have start dates or were not signed for use.

Medical physics support was provided by a local NHS trust, under a service level agreement. Staff were clear on who their radiation protection advisor and medical physics expert were and could describe how to contact them. We saw evidence in incident logs of the medical physics experts' input in incidents involving radiation or requiring advice.

The service ensured all staff underwent appropriate checks as required by Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff were recruited in line with national guidance and the effective recruitment process ensured staff were competent, capable and confident in their area of practice. Checks on staff continued professional registrations, where applicable, were undertaken annually by administrative staff.

Management of risk, issues and performance

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

The provider had a current incident management framework and associated procedures policy. The provider had adopted a new risk register which had four risks recorded. All the risks were added and reviewed in June 2022 with clear review dates for all. All risks had a target or current risk rating, mitigation and a clear owner. However, staff were open and told us this had only begun after Glastonbury festival 2022 and the system for formal review of risk was still being developed and tested.

The provider had a programme of clinical and internal audit to monitor quality and operational issues, but it was not clear where this information was reviewed and acted upon within the governance framework.

The service did not have back up emergency generators in case of failure of essential services. This was not possible due to the location of the x-ray unit. A contingency plan was recorded as part of the Emergency Preparedness, Resilience and Response (EPRR) policy which stated patient requiring imaging would be diverted to the local NHS trust.

Staff were kept informed of audits, themes and safety issues through event staff meetings.

The service had remote operations and maintenance support from the company which supplied the mobile unit. Staff told us all previous maintenance issues had been investigated and dealt with swiftly. Staff were aware of how to contact an engineer out of hours if needed.

Diagnostic imaging

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 secure. Data or notifications were consistently submitted to external organisations as required.

The unit had simple systems all staff could access.

Quality information was collated through patient, referrer and staff surveys, clinical audits, service reviews and key performance indicators. The service did not have an electronic information and patient record system due to the nature of the environment it operated in.

The service had a range of policies including information security and procedures relating to radiation exposure. The confidentiality of electronic and paper-based patient information was maintained, and staff had access to the general data protection regulation policy.

Images taken on the x-ray unit were burnt to a hard disk at the end of each day and stored on site at the providers head office. Paper request forms were also stored but were not scanned electronically. However, managers told us that when the service moved offices, the storage room for the image disks was fireproof.

Engagement

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

Patient's views and experiences were gathered and acted on to shape and improve the services and culture. The service asked for feedback following each festival. Feedback was used to evaluate the service and the feedback we reviewed was mostly positive.

Staff meetings were held each month. Staff told us a variety of things were discussed including serious incidents, audit results, changes to policies and any data protection. However, there was no standard agenda that leaders followed to ensure consistency of conversations.

There was transparency and openness with all stakeholders about performance and the latest Quality Accounts 2020/21 were available on the providers website to download.

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.

Leaders and staff strived for continuous learning, improvement and innovation. A new governance lead for the service was developing a pre event checklist which covered all key safety and governance areas. They had tested it once during one of the 2022 festivals and were planning to review and change it to implement fully in the 2023 event season.

Managers planned continuous development of the service by listening to staff feedback, developing assurance documents and continually explored initiatives to improve patient experience alongside event organisers.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures	<div>Regulation 17 HSCA (RA) Regulations 2014 Good governance</div> <div>Governance processes were not yet fully developed and embedded and did not review and encompass all available information, including risk and incident data for the service.</div>