



# The Clatterbridge Cancer Centre NHS Foundation Trust

## Radiotherapy and Radiology Service Review

Visit Date: 21<sup>st</sup> & 22nd January 2020

Report Date: March 2020



8831



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## Introduction

This report presents the findings of the review of The Clatterbridge Cancer Centre NHS Foundation Trust that took place on 21<sup>st</sup> and 22<sup>nd</sup> January 2020. This was a formative review. The purpose of the visit was to review the quality and safety of services against a number of agreed questions:

- Is the service appropriately managing and monitoring quality and safety performance?
- Are appropriate quality and safety checks being undertaken?
- Is there a culture of 'safety first' in the service?
- Are there effective reporting systems allowing quality assurance for senior leaders?
- How does the organisation use and share safety data and information for learning, service improvement and better outcomes?

The aim of the formative review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The report also gives external assurance of the care which can be used as part of organisations' Quality Accounts. For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where developments may be needed.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Any immediate risks identified include the Trust's proposals for actions to mitigate the risk and QRS's response to those proposals. Appendix 1 lists the visiting team that reviewed the services. Appendix 2 contains details of the information seen by the visiting team, and Appendix 3 lists the formative review questions and the question prompts.

This report describes services provided or commissioned by the following organisations:

- The Clatterbridge Cancer Centre NHS Foundation Trust
- NHS Wirral Clinical Commissioning Group

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches; some require commissioner input. Individual organisations are responsible for taking action and monitoring this through their usual governance mechanisms. The lead commissioner for the service concerned is responsible for ensuring action plans are in place and monitoring their implementation, liaising, as appropriate, with other commissioners, including commissioners of primary care. This report was commissioned by The Clatterbridge Cancer Centre NHS Foundation Trust

## About the Quality Review Service

QRS is a collaborative venture between NHS organisations to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews (often through peer review visits), producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of QRS is available at [www.qualityreview servicewm.nhs.uk](http://www.qualityreview servicewm.nhs.uk)

## Acknowledgments

Quality Review Service would like to thank the staff and service users and carers of The Clatterbridge Cancer Centre NHS Foundation Trust for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

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## Clatterbridge Cancer Centre

The Clatterbridge Cancer Centre NHS Foundation Trust (CCC) was one of three specialist cancer trusts in England and served the population of Merseyside and Cheshire. In addition, the Trust provided oncology services for the Isle of Man and for some patients from North Wales (brain and central nervous system, brachytherapy, gynaecology and urology). In total, the population served by the Trust was in the region of 2.3 million. At the time of the review the Trust operated from a number of sites, providing radiotherapy at CCC Wirral and CCC Aintree, chemotherapy at CCC Wirral along with seven district general hospitals, and an at-home chemotherapy delivery service. Haemato-oncology was provided at Royal Liverpool Hospital and radiology at CCC Wirral.

The Trust was building a new cancer hospital in Liverpool which would become the Trust headquarters. This was expected to be open from May 2020. Once opened, all inpatients would move to CCC Liverpool, and services would reduce at CCC Wirral. However, some outpatient services and radiotherapy, chemotherapy and radiology services would remain to serve the local population.

The Trust continued to maintain a financially stable position and operated two subsidiaries, PropCare® and PharmaC®. The Trust also operated a joint venture, The Clatterbridge Clinic with The Mater Private Healthcare, offering private cancer services to patients.

The chief executive officer of the CCC was the chair of the radiotherapy network board and also the chair of the Cheshire and Merseyside Cancer Alliance.

### 2018/19 Attendances

Service	Attendances*	Growth predicted for 2019/20
Chemotherapy	63,005	5%
Radiotherapy	86,762	1%
Bone Marrow Transplant	82	7%
Protons	1,366	1%
Admitted Patient Care (Inpatients)	2,997	1.5%
Admitted Patient Care (Day case)	4,963	1.5%
Outpatient Consultations	152,015	1.6%
Outpatient Procedures	19,575	1.6%
Radiology Activity	17,599	Not specified

\*Note these are total attendances, not unique patients.

The Trust was organised into four clinical directorates: chemotherapy services; integrated care; haemato-oncology; and radiation services. The directorates all reported directly to the Trust's director of operations.

The radiation services directorate comprised radiology and radiotherapy (including low energy protons) and the medical physics service. Medical staff within the directorate included all of the clinical oncologists and radiologists. Total staffing in the directorate was circa 250 head count.

### Radiotherapy

The service operated nine linear accelerators (linacs) and had additional available capacity of 0.25 linac via a private joint venture. Capacity was planned to increase to 10 linacs from 2020 with the opening of the new

hospital. The service operated a high dose rate (HDR) brachytherapy service offering three sessions per week, mainly for gynaecology and urology cancers, although there were also smaller rectal and skin cancer services. Radiotherapy planning was carried out at CCC Wirral and CCC Aintree. Orthovoltage skin treatments were delivered at CCC Wirral and there was a Papillon® contact therapy service for rectal tumours, also at CCC Wirral.

A low energy proton beam therapy service was provided at CCC Wirral for circa 225 patients per year.

### Current Equipment Capacity

Site	Linacs	Planning CT	Protons	Brachytherapy	Papillon	Orthovoltage
CCC Wirral	6.25 (+0.75 private)	1	1	1	1	2 (different energy ranges)
CCC Aintree	3	1	0	0	0	0

### Equipment Capacity 2020 onwards

Site	Linacs	Planning CT	Protons	Brachytherapy	Papillon	Orthovoltage
CCC Wirral	2 (+1 private)	1	1	0	0	2 (different energy ranges)
CCC Aintree	3	0	0	0	0	0
CCC Liverpool	5	1	0	1	1	1

### Radiology

The radiology service operated from CCC Wirral and offered CT, MRI, plain film, fluoroscopy, ultrasound, nuclear medicine and PET/CT radiology. After May 2020 these services would be retained at CCC Wirral and, in addition, CT, MRI, PET/CT, plain film, fluoroscopy, ultrasound and interventional radiology would be delivered on the CCC Liverpool site. Radium treatments would be delivered on both sites.

The service was currently working towards attaining the Quality Standard in Imaging (QSI)<sup>1</sup> and had an assessment visit booked for February 2020 which was unfortunately cancelled by QSI. It is anticipated that assessment will now take place in July 2020.

### Equipment at the time of the review (2019)

Site	CT	MRI	PET/CT	Gamma Camera	X-ray	Fluoro	IR	U/S
CCC -Wirral	1	2	1	1	2	1	0	1

<sup>1</sup> Developed by the Royal College of Radiologists and the Society and College of Radiographers, the QSI standard accreditation provides assurance to patients, the public and staff that services are safe and of high quality. The Quality Standard for Imaging (QSI) was previously known as the Imaging Service Accreditation Scheme (ISAS).

### Planned equipment (2020 onwards)

Site	CT	MRI	PET/CT	Gamma Camera	X-ray	Fluoro	IR	U/S
CCC -Wirral	1	1	1	1	2	1	0	1
CCC - Liverpool	1	1	1	0	1	1	1	1

### Workforce

Non-medical staffing was reasonably stable and there were no high vacancy rates across the directorate. However, medical staffing was an issue with significant shortages in both the clinical radiology and clinical oncology workforce.

Radiotherapy had introduced consultant radiographers in breast, prostate, lung and palliative radiotherapy which had helped to support the clinical oncology workforce. The clinical scientist workforce (medical physics experts) had taken on 'prescription to protocol' (where senior staff planning a treatment would proceed with the plan without further oncologist approval if it met the dose constraints set out in the protocol) for some radiotherapy plans to support the clinical oncology workforce.

Imaging radiographers had been trained in chest reporting and RECIST<sup>2</sup> reporting which supported the radiology workforce. Further development was planned in other areas of the workforce, including extension of the sonographer role to release radiologist time.

### Rationale for the QRS External Safety Review

The CCC had previously held a Care Quality Commission (CQC) rating of "Outstanding" from its June 2016 inspection, when both radiology and radiotherapy were reviewed. In its December 2018 to January 2019 inspection, the CCC rating was "Good" because of a number of issues including the governance structure of the Trust, statutory and mandatory training compliance and other observations made during the inspection. In the June 2016 inspection, radiotherapy received an "outstanding" rating and this was maintained in 2018 although the service was not inspected in detail. In 2016, radiology had been rated as "Requires Improvement" which was raised to "Good" at the 2018 inspection. However, there were comments within the CQC radiology report indicating that the service did not have a good safety culture.

There had been a number of incidents across the directorate in 2018 and 2019 that had given the Trusts new executive management team some concerns around the safety culture of the directorate and the directorate leadership team were asked to review and provide assurance that there was a good safety culture in place. Whilst some work had already been undertaken by the Trust in order to measure and improve quality, a decision was made to undertake an external review of the directorate services, with a view to assessing the safety culture.

The internal team had carried out a review with radiology staff reviewing radiotherapy and vice versa and the reports from those reviews were available to the QRS review team.

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<sup>2</sup> Response Evaluation Criteria in Solid Tumours (RECIST) is a set of published rules that define when tumours in cancer patients improve (respond), stay the same (stabilise), or worsen (progress) during treatment.

## Formative Review Questions

The following questions were agreed as the framework for the formative review.

They can be found with the detailed prompts in Appendix 3.

1. **Is the service appropriately managing and monitoring quality and safety performance?**
2. **Are appropriate quality and safety checks being undertaken?**
3. **Is there a culture of 'safety first' in the service?**
4. **Are there effective reporting systems allowing quality assurance for senior leaders?**
5. **How does the organisation use and share safety data and information for learning, service improvement and better outcomes?**

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## Radiotherapy Review

The radiotherapy service at the CCC was reviewed on 21<sup>st</sup> January 2020. Members of the review team are listed in Appendix 1. Two members of the team were present for both the radiotherapy review and the radiology review.

The review team were based on the CCC Wirral site. Members of the team also visited the CCC Aintree site and met with therapeutic radiographers.

Note that there are some themes that are common across the radiotherapy and radiology services. They have been annotated in the first report as service wide issues and therefore have not been repeated in the second report.

### Clinical Staffing

At the time of the review there were:

- 32 clinical oncologists (30.23 wte).
- 154 therapeutic radiographers (140.65wte).
- 58 physics and technical services staff (55.88wte).

All staff had up to date professional registrations which were recorded by the service.

Mandatory training compliance at the time of the review was summarised as follows:

- Therapeutic radiographers showed good compliance with the exception of Adult Safeguarding level 3, where compliance was 69.23%; however the Trust confirmed that Level 3 safeguarding training had only recently been added to mandatory training.
- Clinical oncologist mandatory training was variable with six out of sixteen areas showing low compliance. The lowest level recorded was 50% compliance for mandatory training for Adult Life Support Level 2. Compliance was also low in Infection Prevention and Control level 2 (66.67%); Information Governance (53.33%) and Safeguarding Children level 2 (71.43%).
- Physics staff showed low compliance for one out of nine mandatory training topics - Prevent awareness.

**Concern:** Reviewers were very concerned about the low level of compliance for adult life support training amongst the clinical oncologist workforce. As part of a focus on safety the service must review its compliance with mandatory training especially for consultant clinical oncologists.

### Patients' Experience of Care

The review team met a number of patients during the visit. All patients were positive about the support they had received and the quality of care given. Patients noted that staff were consistently helpful and caring. The comments received were entirely positive and reflected an overall view of an organisation committed to patient centred care.

The radiotherapy department on the Wirral site had a patient experience noticeboard. Patients and carers were able to obtain cards from the reception desk, write their comments and pin them to the notice board. The board acted as a 'trip advisor' board for other patients. The cards from the reception desk asked people to identify what the service could do to improve, or areas where the service had met their needs. Reviewers noted that some patients had used their own note paper to pin to the board. Reviewers were very impressed by the idea of displaying patient feedback in this open way and saw it as an effective measure of patient satisfaction. Not all notes were dated. The visiting team noted that the oldest comment dated to 27<sup>th</sup> May 2016. Staff told the reviewers that they would keep comments that they liked on the board. The board would benefit from a regular

refresh both to keep it current and to avoid it becoming so crowded that it patients were discouraged from adding comments because they were unable to find space.

Staff clearly saw the benefit of obtaining and using patient feedback to develop and improve the service.

Staff on both sites were able to articulate clearly the plans for the new centre and were excited about the forthcoming change. The plans were at a highly advanced stage and the team appeared to have considered all reasonable scenarios. Members of the team who spoke to reviewers were eager to see the new centre open. Whether staff were moving to the new centre or initially remaining at one of the two local services, everyone was keen to talk about the development and the way in which it had created a central vision for the service. Reviewers saw that the local and Trust leadership had created a unifying vision and culture that brought the service together.

The service was committed to the Trust patient experience strategy. This was co-produced with Healthwatch and other patient groups. One of the pledges related to a shadowing scheme, where a member of the clinical team 'shadowed' a patient during the patient's visit to the hospital. This allowed the clinical team to understand and reflect on the issues faced by patients and consider how these could be resolved.

The radiotherapy service area on the Aintree site was bright and spacious, and appeared well designed. Whilst reviewers did not talk directly to patients on this site, they observed high-quality and professional interactions between patients and staff consistent with the patient feedback on the Wirral site.

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## 1. Is the service appropriately managing and monitoring quality and safety performance?

The service operated a Q-Pulse<sup>3</sup> quality management system under the International Organisation for Standardisation (ISO) standard. There was a dedicated quality manager leading the management of the quality system. The quality manager was also the service governance lead. The service operated the quality management system to drive a consistent approach to clinical delivery.

Reviewers noted that the file structure for the quality system documentation was not easy to navigate. It had been identified that there was more work needed to order the files in an intuitive way. Reviewers were unable to identify a robust process for analysing or auditing trends in the data held within the quality system.

The visiting team saw that the service had a range of protocols to guide the clinical delivery of radiotherapy. Whilst some of these protocols were in date and had been agreed (e.g. the lung cancer protocol); others some (e.g. the head and neck cancer protocol) were not yet fully agreed and some had been in draft form for nearly 18 months. A requirement of the quality management system meant that each time the draft protocol was used, the service had to formally recognise that it was a deviation from the formal protocol resulting in a concession being issued and a note in the patient record reflecting that the consultant had authorised a deviation from the agreed protocol. This process should be reserved for necessary clinical changes rather than routine treatment decisions. It was also clear that there was limited agreement about what constitutes a concession and what is clinical judgement. The review team were concerned that there had not been any progress in agreeing the remaining protocols.

Agreeing protocols and concessions should be undertaken through a functional peer review meeting. Reviewers were concerned to hear that instead, this was largely done through a medical clinician process, and not a multidisciplinary peer review meeting. A peer review meeting would be an ideal forum for debating clinical judgement versus concession in a multidisciplinary peer to peer setting. Reviewers noted that there is robust guidance from the Royal College of Radiologists relating to the structure and function of peer review meetings, and that this guidance did not appear to be in use within the service.

There was evidence of learning from incidents. A 'pause and check' protocol<sup>4</sup> was in place, and reviewers noted that compliance with this had been audited; with the results showing good compliance with the protocol. The 'pause and check' poster was laminated and placed on the wall in clear sight of all staff members. The service may want to consider its approach to process audit to avoid observational bias as in some cases it was reported that staff were aware of the audits of compliance being undertaken, which would automatically improve the observed outcome.

The service operated a 'sterile cockpit'<sup>5</sup> concept; where all safety critical procedures were recognised; and those undertaking them were clearly identified so that they were not disturbed. For example, there were signs on the backs of the chairs of the therapeutic radiographers checking the final parameters and initiating the radiation exposure stating that the radiographers were not to be disturbed. The Trust had plans in the new centre for these chairs also to be coloured red to further distinguish them from other chairs. The treatment planning team had worked to minimise the number of distractions (quiet areas) to consultant oncologists during the planning process reducing the risk of distraction error. Staff in planning were aware of the need to avoid conversations in

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<sup>3</sup> Q-Pulse is a series of integrated software applications designed to assist with the information management of numerous quality activities across an organisation.

<sup>4</sup> Pause and Check is an acronym used to ensure a standardised approach to safety is adopted. The Society and College of Radiographers have published a range of these for clinical use. [Click here for details](#)

<sup>5</sup> The NHS has adopted many safety developments from the aviation industry. The Sterile Cockpit Rule is a regulation stating that during critical phases of flight (normally below 10,000 feet), only activities required for the safe operation of the aircraft may be carried out, and all non-essential activities in the cockpit are forbidden.

these areas. From experience, reviewers observed that there was a risk that if these processes were not rigorously enforced, they could cease to be routine practice over time. Those responsible for managing these areas must maintain the discipline of these important safety developments.

Reviewers saw that a Datix®<sup>6</sup> huddle was held regularly where issues, concerns and incidents were shared widely between staff. Reviewers saw that video conferencing existed between the Wirral and Aintree sites so that information could be easily shared and staff could meet as a virtual team. The Trust may wish to note that the video conferencing equipment at the Aintree site was of a lower specification than at the Wirral site. When screen-sharing of protocols or images was undertaken, the Aintree site no longer had visual video contact with the team at Wirral, although Wirral had full video contact at all times. When the new CCC Liverpool service opens, the CCC Aintree site will be at a significant disadvantage if this technology remains at a lower specification.

Reviewers saw that the Datix® incident reporting and management system was apparently understood by staff who were able to use the system. From the information shared with the visiting team; it was noted that there was limited evidence of low and no harm incidents being reported. The folder shown to the visiting team included only reportable incidents. For example, in December 2019, ten incidents had been reported<sup>7</sup>. Reviewers were told by staff that there were no concerns about reporting incidents; staff described a 'no-blame' culture in the organisation. The 'Just Culture' guide produced by NHSI has recently been introduced by the Trust in support of an appropriate response to the investigation and reporting of incidents. However it should be recognised that some staff told reviewers that they felt there was a culture of over-reporting. Reviewers were confident that staff could report incidents through the Datix system. A strong reporting culture in an organisation is supported by regular reporting of low and no harm incidents. This recognises that a 'near-miss' can be used as learning to prevent future incidents.

Where incidents had occurred, staff were able to articulate the reasons and causative factors along with the learning. For example, in one case a pelvic cone beam CT protocol had been used for a thorax treatment. This was appropriately reported to the CQC IR(ME)R team. Staff were able to explain why the incident had occurred (distraction), the changes made (restricted access, signs on chairs, staff availability). Reviewers identified in this the elements of a good learning and improvement culture.

There was a two-weekly process of reporting back to staff from Datix reports in a staff meeting. This had been well received by staff.

The Trust had a daily incident conference call in which all incidents across the Trust were shared with representatives from each service. This allowed service leads to be sighted on incidents in a timely way, to begin to take action if necessary and to reflect on any potential risk for their service.

The safety culture within the physics service had improved over the past five years. Historically, reviewers understood that some processes (for example equipment commissioning reports) were seen as a low priority and were not immediately completed. The completion of procedures and outstanding actions had improved, although a continued focus on this area would avoid the service slipping back.

Q-Pulse was also used by the radiation service to manage its document control, store and distribute protocols and procedures and manage the quality function for the services. Some staff told the visiting team that changes

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<sup>6</sup> Datix is a web-based incident reporting and risk management software in regular use in the NHS.

<sup>7</sup> Following the review, the Trust clarified that reviewers had been shown only the incidents that the Trust thought reviewers should see. Additional data now seen indicated a reporting profile that would be expected from a Trust of this size. The Trust have since confirmed that *"in December 2019, the Radiation Services Directorate reported a total of 81 incidents with 60 of those from radiotherapy staff. There is considerable evidence of low harm, no harm and near miss reporting within Datix. Last year (2019) there were 1116 Radiation Services incidents, 949 of these were no harm, 43 low harms and 113 near misses"*.

to protocols and procedures were not always effectively communicated. Reviewers identified that the distribution list within Q-Pulse, and the system of receiving acknowledgements, may not be being used as effectively as possible. In the week leading up to the QRS visit; the service had released 90 quality documents as part of an update. Reviewers noted that it would take staff a considerable time to understand and process these changes. This would lead to a risk that some staff may have not understood all of the changes and may be working to different protocols. It was clear that there was insufficient time available to manage the quality system and this is discussed later in this report.

In discussion with clinicians, it would appear that some clinicians were not routinely using Q-Pulse as the repository of protocols. This was a significant concern as there is the clear potential for different forms of the same protocol to be referenced. It was also concerning that some staff groups may be working outside the Trusts agreed quality system.

A good approach to change management within the service was seen with a project management approach, where the proposer of any change presented it to a project board for approval. This was seen as a good approach to managing change ideas. Reviewers noted that this process would benefit from the inclusion of a quality impact assessment methodology where possible or from actual plans being assessed and the potential consequences on quality formally considered in a structured way, along with any necessary mitigating actions.

#### **Conclusion:**

- The process for agreeing clinical protocols was not robust with some protocols long outstanding for agreement. The process for peer review did not follow national (Royal College of Radiologists) guidance.
- The quality system required improvements to the folder structure to make it effective and more intuitive. The efficacy of the quality system was undermined because documents were stored and accessed from multiple locations which increased the risk of out of date or alternative processes being used.
- Process audits provided limited assurance because of the methodology used.
- A robust approach to safety-critical tasks was observed.

## **2. Are appropriate quality and safety checks being undertaken?**

The use of the 'prescription to protocol' approach had been introduced in a robust way. The approach had been agreed by the Site Reference Group (SRG), and the pathways in which it would be used had been approved by the consultant. There was a process in medical physics to test, track and challenge deviations during the planning process.

The treatment planning process adopted a tracking system to ensure that the start dates for patients' treatment were achieved by setting interim dates for each stage of the process. Reviewers saw that this was separate from the formal systems and therefore required time to administer; however the success of this approach (reducing time to start treatment from 14 days to 8 days) meant that the process was highly effective. Staff were rightly proud of this achievement.

Error codes (which were recommended in Towards Safer Radiotherapy<sup>8</sup> 2008) were used for in-process planning checks and were recorded in the treatment planning system. However, whilst over 18 months of data existed, the service had not made time to analyse these data for trends and learning. The service will want to make best use of the data collected in a timely manner. Issues found in the treatment planning process were also recorded on Datix.

The service had clear operational and clinical delivery protocols stored in the Q-Pulse quality management system. Reviewers looked at the Q-Pulse system and (as previously discussed) identified that it was not

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<sup>8</sup> [https://www.rcr.ac.uk/system/files/publication/field\\_publication\\_files/Towards\\_saferRT\\_final.pdf](https://www.rcr.ac.uk/system/files/publication/field_publication_files/Towards_saferRT_final.pdf)

structured intuitively and was complex to navigate. Finding protocols, procedures and work instructions could be a challenge, especially for new staff, who may need to rely on these procedures to a greater extent.

Some of the protocols seen by the reviewers, for example imaging protocols, appeared over-complicated. Reviewers noted that there was a variable knowledge amongst staff of the concomitant imaging protocol. Staff reported that they had 'simplified' the imaging protocols. Whilst understandable, this risked several 'versions' of a protocol being in use. The service will want to ensure that the most up to date version of the protocol is both easy to identify and easy to understand.

There was an 'unwell patient' pathway in place and staff who spoke to the review team were aware of this. There were training records for this (which were managed on line) to show that staff had read the protocol.

There was a good system in place for staff rotation of therapeutic radiographers between CCC Wirral and CCC Aintree. Those staff with a nominal base at one site had clearly identified time at the other site to support sharing of learning. Radiotherapy physics staff worked at CCC Aintree on a daily rota basis. Physics staff were able to undertake CCC Wirral work on the CCC Aintree site through an integrated IT work system, and so were able to be productive at either site.

A 'work-around' is a process in which an individual or group of people adapt a protocol or process to suit a unique set of circumstances. Used in an uncontrolled way work-arounds have the ability to deliver non-standard approaches. A concession process was now in place within medical physics to manage or limit the use of work arounds. This process appeared to be effective; however staff commented that obtaining approval could cause delay.

#### **Conclusion:**

- There were robust safety systems in place with a focus on safety-critical procedures.
- The radiotherapy service operated as one service based on two sites. Processes were the same in both locations. Staff were able to work on either site.
- Some protocols were overcomplicated, leading to some staff developing their own version. However; the culture of using work-arounds had largely been eliminated.
- Analysis of existing safety data already collected in systems would aid and improve learning.

### **3. Is there a culture of 'safety first' in the service?**

Reviewers saw that approaches and systems of safety were included in induction training for new staff, but it was unclear how these new members of staff were signed off as competent in using these systems

In discussing the safety culture with the review team, staff indicated that there was an open and honest environment in which they felt issues could be raised without fear or concern. Staff were open to ideas of improvement and keen to improve the service and the outcomes for their patients.

Reviewers were told "we aim to be outstanding in all areas – but we should start with patient safety". This reflected the overall safety culture seen on the visit.

Respect between radiographic, medical physics and medical staff was evident. Staff groups largely recognised the roles that other groups provided. However, the medical physics team suggested in their discussions with the reviewers that, whilst they were able to raise concerns and challenge practice, they sometimes felt that their clinical oncologist colleagues did not always recognise their role in this area, and they sometimes felt ignored. Reviewers identified an opportunity to buddy physics staff with registrars to improve training and learning, which could be helpful.

There were clear training records for staff, and these were monitored routinely for compliance. Reviewers noted that they were stored in an Excel spreadsheet that appeared very complex and detailed. This level of complexity may be necessary in some areas, but a simplified 'at a glance' version would support the process.

From discussions with some staff, reviewers identified a perceived concern about challenges to decision making in some areas, especially when critical or complex decisions needed to be taken. At an operational level, it was reported that some decisions were easily changed as the result of challenge from others. This made it harder for the divisional management to feel confident that appropriate decisions had been made.

The service should review its approach to infection control. Reviewers saw a number of staff members outside of the Trust building in their work uniforms. Reviewers were unable to see the Trust infection policy or uniform policy. Following the review, the visiting team was sent the Trusts 'Uniform And Dress Code Policy V6.1' Dated March 2019. This confirms that if uniforms are covered, wearing uniforms to and from work and when moving between hospital sites is allowed. Reviewers noted that a number of organisations are considering the risks involved in staff wearing clinical uniforms, especially on public transport. The Trust will want to consider this as part of the next planned review of this policy.

#### **Conclusion:**

- Reviewers saw a strong approach to safety systems, with an open culture of mutual respect. There were however a few notable counterexamples.
- The approach to safety in training and induction was good. The poor training of clinical oncologists in life support is an outlier in otherwise good practice.

## **4. Are there effective reporting systems allowing quality assurance for senior leaders?**

The Trust had a clear structure for its Board sub-committees. This matrix was of similar design to that used by many Trusts. Reviewers identified from the organogram seen at the review that, for operational staff, the 'line of sight' to the Board appeared complex. Staff reported that they felt the process to be one-way, with issues being escalated and limited feedback being received. The Trust may find it helpful to translate the required NHS Committee Structure into a easier to visualise structure for local use. This would aid operational staff understanding of the reporting and engagement process.

Safety was seen as a clear priority for the organisation and the service. Safety was clearly identifiable in the agendas of appropriate meetings and discussions. Senior leaders were appropriately focused on a safe clinical service. There was a clear understanding that everyone in the service was trying hard to provide safe and effective care.

The Trust had introduced an Assure, Advise, Alert (AAA) process designed to avoid harm in radiotherapy processes. **Assure** that all is OK; **Advise** if the problem still exists but all is in control; **Alert** if the problem is out of control and needs escalation. This process was found to be helpful and was well understood. A number of staff pointed out that when this process had resulted in escalation (Alert stage) to board level, they had not always received feedback or responses.

Reviewers looked at the action plans created by the service. Plans were discussed at the directorate quality and safety committee and recorded on the Datix system. Reviewers identified that the action plans they saw would benefit from development. The action plans lacked detail on the progress leading to conclusion, mitigation if actions were not immediately possible and clarification of timescales. Action plans would also benefit from evidence to support the implementation of the output and recommendations. There did not appear to be a clear process for the dissemination of the outputs (for example of a root cause analysis) following an investigation.

In some areas there was no clearly identified person who was responsible for chasing progress in operational meetings. In some minutes of meetings for the radiotherapy service, there appeared to be little progress on some important actions from previous meetings. In one case (radiotherapy services directorate meeting 27.11.19), reviewers saw that a key action of entering an issue on the risk register remained outstanding at the next meeting. This omission appeared to be of little consequence, and, instead, the action was rolled over to the next meeting. Where actions were achieved, the minutes just recorded 'completed', with no detail of the final actions or outcomes. Much of the burden of chasing progress fell to the heads of service, who had neither capacity nor operational detail to undertake this effectively. Reviewers were unable to identify a sense of urgency for some of the unfulfilled actions and lacked confidence in the process of driving change and holding challenging conversations at operational service delivery meetings.

There was a significant opportunity to develop the operational management capacity within the service. The review team identified that the heads of service carried a heavy load that also included some operational components. It would be appropriate to delegate some of these operational duties to other senior staff in the service. This would also allow these staff to develop into their role with support and learning.

As previously discussed, Q-Pulse is the quality management system for the service. The governance lead was also the lead for the Q-Pulse system, which created a strong relationship between the oversight of the governance and the system for delivering it. Reviewers were, however, very concerned that the person managing the system had insufficient time available to do so effectively. This individual was doing a good job in the time available, but the potential system development required additional input. The structure of the system required organisation to make it more intuitive and easier to navigate, and protocols and work instructions should be released in a controlled way so that staff had time to digest the release of information. Supporting the development and sign off of protocols and their integration into the system requires dedicated time.

#### **Conclusion:**

- The committee structure used by the Board, would benefit from simplification at local level to allow staff to understand the Board's line of sight at an operational level.
- There was a focus on safety and reporting.
- Staff were unable to identify the response from the escalation of concerns to the executive team (e.g. through the AAA process). Greater consideration of communication and cascade methods would be helpful.
- Actions plans and meeting structures required more rigour. Failure to progress was not addressed within meetings.
- Development of the middle tier of radiotherapy management would support stronger communication and progress on action plans.

## **5. How does the organisation use and share safety data and information for learning, service improvement and better outcomes?**

It was clear that the service was actively moving forward with new techniques and staff should be celebrated for their continued development of the clinical radiotherapy service.

The service had a good approach to becoming paperless/paper-lite. It was noted that this appeared to be working well.

There was a good process for embedding radiotherapy services in the Trusts quality meetings, but some radiotherapy staff reported that they felt the need to justify what their professional role could contribute to the Trust's quality meetings. The Trust had a significant number of allied health professionals (AHP) in its workforce. The AHP role as a focus for quality could be further explored by the Trust. In the radiotherapy service, the nursing

input is limited. AHPs can learn from nurses approach to quality and nurses in return can learn from AHPs. A stronger partnership between the non-medical workforce and its approach to quality would benefit the Trust.

Some radiographic staff were named as patient safety leads within the service, which was the equivalent of the 'Matron' role elsewhere but in fact they were radiographers. Staff the reviewers spoke with were concerned that they were perceived as Matrons by the wider Trust. Radiographers bring an important perspective to quality and safety that can inform nursing views, and equally radiographers are able to learn from a nursing view. It was not clear how the Trust was managing the development of radiographers in these nominated roles and ensuring the exchange of ideas with nursing colleagues.

As discussed above, reviewers heard that there were three possible locations for the storage of operational protocols and documents. Q-Pulse; the intranet and the radiotherapy shared drive. Protocols were stored in Q-Pulse and on the intranet, minutes, action plans, reports and related documents on a shared drive. Reviewers were concerned that the Trust governance processes were not clearer in restricting the number of locations where information is stored and shared. There was a risk that changes may not be made in all three locations at the same time and could lead to errors. This also raised concerns that the version and document control processes within the Q-Pulse system may be ineffective. Reviewers would strongly recommend a single location that is capable of being directly managed by the service quality system.

Radiographers reviewed incidents every month and checked that nothing was missed from an investigation. Lessons learnt sessions had been introduced to give feedback to staff and to share learning from incidents. There were regular discussions between the planning team and physicists about planning and process issues. However, there was no robust process in place for analysing trends in safety data over a period of time. Looking at themes is important as part of a preventative framework.

The Trust currently has an interim clinical director of radiation services, who is covering this role along with the role of clinical director of another key division. The attendance of this postholder at important meetings for this division has been difficult because of the existing timing and commitments. Securing the clinical director in a substantive role must be a priority for the service. This will allow attendance at important meetings such as the radiotherapeutics committee. Reviewers noted that the Trust had made significant progress but had been unable to appoint to the post. The trust is encouraged to maintain their high focus on this important role.

The service would benefit from revising its approach to internal reviews. In the internal reviews carried out by radiotherapy of radiology and by radiology of radiotherapy following the latest CQC ratings, the risk profile was aggregated at divisional level. For example, on the front page there was a single level of assurance statement with a global number of risks that were not disaggregated to service level. This made it difficult to see where the risks were occurring and what action needed to be taken, unless one read the whole document in detail. Reviewers were also concerned that the structure of the review questions did not appear to address the concerns raised in the CQC inspection directly. This may have an impact on the ability of the division and the Trust leadership teams to direct improvement actions effectively.

#### **Conclusion:**

- The service was seen to be developing and improving services in a safe way.
- However, the multiple locations used for storing and accessing protocols increased the risk of error.
- A robust approach to sharing key information from internal evaluations would improve the impact of these reviews.
- Internal reviews would benefit from greater rigour.
- Progress to appointment of the clinical director role is a priority for the service. Maintaining the existing momentum for this appointment should remain high.

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## Radiology Review

The radiology service at CCC was reviewed on 22<sup>nd</sup> January 2020. Members of the review team are listed in Appendix 1.

Two members of the team were present for both the radiotherapy review and the radiology review.

### Clinical Staffing

At the time of the review there were:

- 3 radiologists (2.75 wte).
- 40 diagnostic radiographers (33.11wte).
- 3 PET CT staff (2.60wte). This comprised 1.00 technician and 1.60 diagnostic radiographers.

All staff had up to date professional registrations recorded by the service.

The records for mandatory training demonstrated the following:

- Imaging radiographers showed good compliance in all areas.
- Radiologists mandatory training was recorded at 100% in all areas.
- PET CT staff had good compliance for all but one out of the sixteen mandatory training areas - information governance (66.67%).

Overall, compliance with mandatory training was excellent in radiology services.

### Patients' Experience of Care

Two patients met with the review team during the visit and shared their experiences of their care.

The patients were complimentary about the professionalism, understanding and reassurance they received from the staff in the radiology service.

One patient told the visiting team that although they were apprehensive about the planned investigation and treatment programme, the staff they met enabled them to 'feel like a person' in the system.

Communication was described by patients as particularly good.

Patients told the reviewers that they felt staff were honest with them and did not 'sugar-coat' information. Patients felt the information given to them both orally and in written form was easy to understand and they appreciated having information in advance. Patients felt staff included them in discussions.

Reviewers were told about a radiographer who had made time to ring a patient about whom they were concerned to check on their welfare. Reviewers concluded that the patient care from the team was not just focused on the time of the radiology investigation and was truly holistic.

The visiting team reviewed the November 2019 imaging Service Patient Experience Questionnaire and saw

- 100% of patients said staff were professional.
- 99% of patients said staff introduced themselves.
- 98% of patients were satisfied with their waiting times
- 97% of patients rated their visit to imaging was excellent or very good.

However

- 12% of patients said they were not aware that they could call the imaging department with queries
- 19% of patients said they were not kept informed of any delays

Reviewers identified that the radiology service might benefit from the same patient experience notice board that was in place in radiotherapy. Whilst many radiology patients do not return regularly, their comments will be helpful to the service and other patients.

The service was committed to the Trust patient experience strategy. This was co-produced with Healthwatch and patient groups. One of the pledges related to a shadowing scheme, where a member of the clinical team 'shadowed' a patient during the patient's visit to the hospital. This allowed the clinical team to understand and reflect on the issues faced by patients and consider how these could be resolved.

There was an excellent volunteer service in both radiology and radiotherapy that supported patients and helped staff to deliver patient-focused care. Both staff and patients praised the volunteers for their incredible work, which was highly valued. The review team noted that only three of the 90 volunteers would be moving to the new Liverpool site. The service was already preparing to ensure this level of support can be maintained in the new hospital.

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## 1. Is the service appropriately managing and monitoring quality and safety performance?

There was a good culture for the reporting of incidents in the service. Staff felt able and confident to raise incidents. All incidents were recorded on Datix. The use of Datix was actively encouraged by service leaders. Staff told reviewers they had faith that something would get done, but they rarely received feedback. The Trust have since confirmed that feedback is given via Datix when an incident is closed including any lessons learnt. Reviewers were uncertain about the process of follow-up and closure of incidents, as there were a large number of incidents that were still open. There was a daily safety huddle for staff to share information on incidents and near misses.

The service was seen to be undertaking daily safety checks before the first patients were imaged. This was a sign of a strong safety focused culture.

The Trust had a daily incident conference call where all incidents across the Trust were shared with representatives from each service. This allowed service leads to be sighted on incidents in a timely way, to begin to take action if necessary and reflect on the risk for their service.

Reviewers saw that the service was undertaking audits, which included clinical outcome and assurance of compliance with some clinical practice and process.

An incident in PET CT<sup>9</sup> was recognised not to have been handled appropriately when it occurred. Individually, there was low harm to each patient; however as it involved about 300 patients (not all of whom were affected), the incident should have been escalated sooner. An investigation into the incident was undertaken and in response, the service put new systems in place and improved its communication processes. The service was seen to have reflected on this incident and has learnt from it.

Reviewers were impressed with the length of time taken to report scans by radiologists. There was a recognised shortage of substantive Radiologists, and yet the oldest unreported scan seen by the review team was from 17<sup>th</sup> January, which was less than four working days.

The operational manager for the radiology service was recognised by the review team as a highly effective lead for radiology. There was a strong team culture and staff felt well supported. Staff described the positive impact her leadership brought to the service.

### Conclusion:

- There was a good approach to safety monitoring, reporting and learning.
- Leadership in the service was strong.

## 2. Are appropriate quality and safety checks being undertaken?

The service had clear operational and clinical protocols in place. The protocols seen by the visiting team were all in date, although it was recognised that some had been reviewed in the days immediately before the visit. The service have developed a large number of protocols for the forthcoming QSI accreditation which were ready for uploading. Audits of these protocols were not yet complete.

Some protocols were vague on the actual requirements for an examination. For example, the protocol RTP RECTUM – SAG T2 says “...may be angled if necessary” but does not give guidance on by how much this should be angled or in what way.

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<sup>9</sup> Positron emission tomography (PET) is a nuclear medicine procedure coupled with a scan that measures metabolic activity of the cells of body tissues.

Protocols were stored on Q-Pulse although reviewers found the format of this system not to be the most intuitive or usable format with a lack of subfolders and navigation structure. Reviewers were also told that some imaging related documents were also on the intranet. The clinical teams did not have any confidence that these were kept up to date. The Trust should have a single system for managing clinical protocols, procedures and related documents that is capable of being updated and controlled.

Reviewers saw that some paper copies of documents from the quality system, for example radiology local rules, were in place. However a system was in place to replace the paper copies when they were changed or updated. Each document in Q-Pulse had a distribution list, and it was clear to those using the system who required notification of changes and updates. Reviewers were assured that an appropriate system of managing any paper copies was in place.

The service protected staff time for mandatory training which provides assurance that all staff can maintain core competencies in Trust wide safety processes. The results of mandatory training for radiology staff (set out earlier) were impressive.

An audit on the identification of patients before imaging had been undertaken. Staff told reviewers that they had known they were being observed and what audit was being undertaken. This would have had a detrimental impact on the reliability of the audit outcome. These audits should be done discreetly and at random times to avoid observational bias. The service may wish to consider a programme of testing to provide assurance of the validity of the audits outcomes.

Reviewers would encourage the service to focus on routine checks. The resuscitation trolley which should be checked daily, was observed with an empty glove box; the trolley had not been checked for two days and the sheet for the trolley check confirmed this.

**Conclusion:**

- Good progress was being made towards the QSI accreditation.
- There was a good use of operational protocols although some would benefit from greater clarity.
- Audits would benefit from an improved methodology to avoid observational bias.
- Communication of audits underway, and the outcome of completed audits, would improve staff understanding of related issues.

### 3. Is there a culture of 'safety first' in the service?

A safety huddle was in place where staff could receive a rapid cascade of safety updates and share concerns about the forthcoming work programme.

Radiographers in safety-critical roles (see description in the radiotherapy report) were clearly identified and protected from distraction. The scanning radiographer had a designated chair with a 'Do Not Disturb' sign clearly visible. As previously described, these safety critical practices require robust enforcement to ensure they are maintained.

Staff who spoke with reviewers were positive about the recent changes to the service structure and they described an emphasis on quality and safety. All staff were fully engaged with the service and happy to be working there.

Junior staff confirmed they felt valued in the clinical teams in which they worked and felt able to speak up if they were concerned or needed to challenge a process. Staff said that the culture in the service made it clear that the purpose of Datix and incident reporting was not to blame individuals but to encourage learning and improvement.

Reviewers saw that radiographic advanced practice was in place and that the development of radiographers in these roles was actively supported by the Radiologists.

Staff understood and were able to articulate 'Learning from Excellence'. This is system that recognises that learning from when things go well can significantly improve the processes for a service.

One member of staff gave an example of when they had self-reported an incident they had caused. The management of the service had contacted them and congratulated them for doing so. This was a positive example of developing a robust culture of learning.

**Conclusion:**

- A safety first culture was noted. Cascade of safety information was in place.
- Staff were able to learn from good outcomes as well as poor outcomes.
- There was a clear focus on safety critical roles.

#### **4. Are there effective reporting systems allowing quality assurance for senior leaders?**

Reviewers saw clear reporting systems for incidents within the service. Staff who met with the review team were aware of and able to articulate the escalation process.

There was a clear and well-defined management structure in the radiology department. A meeting structure was in place to discuss incidents and consider remedial action and mitigation.

Some radiographic staff were named as patient safety leads within the service, which was the equivalent of the 'Matron' role elsewhere but in fact they were radiographers. Staff the reviewers spoke with were concerned that they were perceived as Matrons by the wider Trust. Radiographers bring an important perspective to quality and safety that can inform nursing views, and equally radiographers are able to learn from a nursing view. It was not clear how the Trust was managing the development of radiographers in these nominated roles and the exchange of ideas with nursing colleagues.

There was a designated governance lead for the radiology service. The post holder was seen to be very proficient in their role. Reviewers noted however, that there was insufficient time and capacity to carry out the role effectively.

Action plans seen by the visiting team would benefit from being rigorously followed up with dates of completion. There was limited assurance from the action plans that the agreed actions had been absorbed into clinical practice. The plans would benefit from detail of the implementation and checking phase. In some action plans a team of people (for example the QSI team) had the ownership of the action, and in some cases there was no ownership listed. All action plans must have a single named lead for completing the action with appropriate timescales noted. Where an action has more than one step the person responsible for each step should be clearly identified. Action plans would be improved by the greater use of enforced deadlines. Staff in the service told reviewers that they would value greater feedback on progress with action plans as these often represented issues they had been involved with or had reported.

A new risk and compliance manager was in post for the Trust reporting directly to the Director of Improvement. The service should reflect on and review its processes to ensure they remain valid within this new system. There were clear plans to develop effective risk management systems; but the service will wish to review these once the operational process at the new hospital are ratified.

The Board Assurance Framework (BAF) is a key mechanism that Trust boards use to maintain strategic focus and better manage risk at an organisational level. The BAF is currently being revised. The service will want to ensure that as it revises its risk management processes, these inform the BAF and support the Board oversight of risk.

The radiology manager had also recently been appointed as lead AHP for the trust reporting to the Director of Nursing and Quality. This will give the AHP workforce a route for communication and representation at the Board.

**Conclusion:**

- Good reporting systems were in place.
- Action plans lacked rigour and strong assurance processes.

## 5. How does the organisation use and share safety data and information for learning, service improvement and better outcomes?

The safety committee was attended by service leads from radiology. Issues raised at this committee, including the AAA reporting, were escalated to the Trust executive team. Staff told reviewers that they were uncertain about the cascade of information back down to the service. Reviewers met with the Director of Improvement who described the process as two-way and said other systems for communication were also in place. The Trust and the service will want to review their communication methods to ensure effective two-way flow of information on safety related data is maintained.

Reject analysis refers to the process of analysing occasions on which an image is judged by the radiographer to be clinically unacceptable and requires repeating. A reporting radiographer was working on a reject analysis of image where patients had a nasogastric tube in situ. This is an important piece of work, but other staff in the service were unaware of this work and the outcomes of the audit. The service should consider a process of awareness and sharing of clinical evaluations.

Some staff told reviewers that there was a delay in them hearing about outcomes of audits. They told reviewers that they did hear eventually; but that they would value hearing sooner so that they can make changes earlier.

Departmental audit meeting are held regularly and all staff are invited to attend; the Trust has since confirmed that these meetings are held in the morning and repeated in the afternoon. At the last audit meeting 41 staff attended. Minutes are available to read which does allow staff to read about the outcomes.

The safety huddles were seen as an effective system of sharing information. Incident reviews were well attended.

The Trust was committed to a funded equipment replacement programme that ensured that patients were receiving examinations with up to date technology.

Please also see the Radiotherapy section of this report for common organisation themes in this key question.

**Conclusion:**

- Systems for sharing information to staff following escalation appeared ineffective. Staff would benefit from greater clarity on the response to issues escalated.
- A good equipment replacement programme was in place.

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## APPENDIX 1 Membership of Visiting Team

### Radiotherapy Tuesday 21st January 2020

Visiting Team		
Dr David Bloomfield	Consultant Clinical Oncologist	Brighton and Sussex University Hospitals NHS Trust
Derek D'Souza	Head of Radiotherapy Physics	University College London Hospitals NHS Foundation Trust
Deirdre Dobson	Deputy Head of Radiotherapy	Guy's and St Thomas' NHS Foundation Trust
Angela Francis	Head of Radiotherapy	Guy's and St Thomas' NHS Foundation Trust
Gordon Prescott	User Representative	Quality Review Service
Claire Puzey	Clinical Technologist	Shrewsbury and Telford Hospital NHS Trust
Chris Rawlings	Deputy Head of Quality Governance	Worcestershire Health and Care NHS Trust

QRS Team		
Tim Cooper	Director	Quality Review Service

### Radiology Wednesday 22nd January 2020

Visiting Team		
Jenny Cooke	Advanced Practitioner Radiographer	University Hospitals of Derby and Burton NHS Foundation Trust
Gordon Prescott	User Representative	Quality Review Service
Chris Rawlings	Deputy Head of Quality Governance	Worcestershire Health and Care NHS Trust
Stuart Simper	Group Manager Radiology	The Royal Wolverhampton NHS Trust
Dr Umesh Udeshi	Consultant Radiologist	Worcestershire Acute Hospitals NHS Trust

QRS Team		
Tim Cooper	Director	Quality Review Service

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## APPENDIX 2 Information seen by the visiting team.

Information was provided to reviewers in both folders and via the Trust electronic systems.

Reviewers were given temporary access to the Q-Pulse quality management system. Reviewers were also given a number of folders which are detailed below with examples of the contents.

<b>Radiotherapy Services</b> <b>Information folders available to the reviewers</b>
<b>Project Committee and Radiotherapeutics</b> Including: <ul style="list-style-type: none"><li>• Project committee meeting minutes</li><li>• Project initiation Document for outlining axilla and SCF nodes and other projects</li><li>• Radiotherapeutics Committee Agenda and minutes</li><li>• Requests to amend protocols</li><li>• Concessions from the quality system</li></ul>
<b>Assorted Documents</b> Including: <ul style="list-style-type: none"><li>• Clinical Safety review reports</li><li>• Agenda and minutes radiation services directorate meeting</li><li>• HDR Prostate capacity documents</li><li>• MRT Radiotherapy planning paper</li><li>• Summary of actions from HSE inspection</li></ul>
<b>Serious Incidents and IR(ME)R Reportable Incidents in Radiotherapy</b> Including: <ul style="list-style-type: none"><li>• Datix incident 2317.2017</li><li>• RCA 2317</li><li>• Incident panel minutes 2317</li><li>• Updated action plan 2317</li><li>• 72 hour safety review Datix 3338</li><li>• Cone beam CT incident 5476</li><li>• Pause and check poster</li></ul>
<b>Radiotherapy and Theatre Audit Reports</b> Including: <ul style="list-style-type: none"><li>• Pause and Check Audit January 2020</li><li>• Audit of planning and Delivery of treatment 2019</li><li>• Pregnancy audit Sept/Oct 2019</li><li>• Patient ID audit Sept 2019</li></ul>
<b>Radiation Services Quality and Safety Meetings</b> Including: <ul style="list-style-type: none"><li>• Radiation Services Directorate Q&amp;S Terms of Reference</li><li>• November 2019 meeting agenda,</li><li>• Notes and actions Oct 2019</li><li>• Triple A Nov 2019</li><li>• Quality and Safety Data Pack Nov 2019</li><li>• SBAR QSI Nov 2019</li></ul>

## Radiology Services

### Information folders available to the reviewers

#### **Audits**

Including:

- Adequate Contrast Enhancement of CT Pulmonary Angiograms Jan 2019
- Audit of weight based contrast in CT March 2019
- Action plan Critical and Urgent Findings Nov 2019
- Audit of radiation doses on CRIS and PACS in CT and X-Ray March 2019

#### **Radiation Services Quality and Safety Meetings**

Including:

- Radiation Services Directorate Q&S Terms of Reference
- November 2019 meeting agenda,
- Notes and actions Oct 2019
- Triple A Nov 2019
- Quality and Safety Data Pack Nov 2019
- SBAR QSI Nov 2019

#### **Serious Incidents and IR(ME)R Reportable Incidents in Radiology**

Including:

- PET CT SUV 2018
- Joint action plan CCC and AML
- PET CT SUV Incident action points 16/04/18
- ToR for external investigation PET CT Incident 16/05/18
- External review of QA processes 25/08/18

#### **QSI/ISAS and assorted documents**

Including

- Letter confirming application for accreditation
- QSI Project plan Jan 2020
- Mock inspection action plan Nov 2019
- HR update

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## APPENDIX 3 Key Questions and Prompts

1. **Is the service appropriately managing and monitoring quality and safety performance?**
  - Is there a single approach to quality and safety uniformly applied?
  - Are near misses and zero harm incidents treated with equal importance for learning?
  - Are near misses and zero harm incidents consistently reported?
  - Are incidents fully investigated?
  - Where RCAs and safety reviews recommend actions, are these being implemented?
  - Are there appropriate checks that the actions are absorbed into routine practice?
  
2. **Are appropriate quality and safety checks being undertaken?**
  - Are there clear operational protocols in place?
  - Are operational protocols up to date and regularly reviewed?
  - Do the individual team members understand the protocols?
  - How do individuals and teams manage non-compliance?
  - Are 'work-arounds' a common practice?
  
3. **Is there a culture of 'safety first' in the service?**
  - Is safety everyone's business?
  - Do individuals feel able to 'call out' breaches of protocol or near misses?
  - Is there respectful challenge?
  - Are safety critical procedures given sufficient prominence (the equivalent of WHO checklist implemented, sterile cockpit concept etc)
  - Is there respect for the input of all disciplines?
  - Are members of the MDT able to speak up/speak out?
  - Are training records routinely monitored for compliance and maintenance of competence?
  
4. **Are there effective reporting systems allowing quality assurance for senior leaders?**
  - Is there a clear reporting process for incidents?
  - Are assurances supported by evidence of implementation?
  - Do senior leaders make safety a priority?
  - Are action plans following incident investigations adequately managed?

5. **How does the organisation use and share safety data and information for learning, service improvement and better outcomes?**

- Is there a quality and safety committee for radiation services?
- How does learning from incidents and near misses cascade down to operational teams?
- Is the cascade consistent?
- How do people who have been away learn of changes to practice?
- How does the organisation benchmark its safety data?

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